HB

211

1-LS0472\M
Ford
3/23/00

CS FOR HOUSE BILL NO. 211(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to liability for providing managed care services, to regulation**
2 **of managed care insurance plans, and to patient rights and prohibited practices**
3 **under health insurance; relating to patient rights under a health care insurance**
4 **plan or contract providing coverage for dental care, and prohibiting certain**
5 **practices by health care insurers relating to dental care; amending Rule 602(b),**
6 **Alaska Rules of Appellate Procedure; and providing for an effective date."**

7 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

8 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new
9 section to read:
10 SHORT TITLE. Section 3 of this Act may be known as the Alaska Patients Bill of
11 Rights.
12 * **Sec. 2.** AS 09.65 is amended by adding a new section to read:
13 **Sec. 09.65.175. Civil liability of managed care entity.** (a) A managed care

1 entity has the duty to exercise ordinary care when making a health care treatment
2 decision.
3 (b) A managed care entity is civilly liable for damages for harm to a covered
4 person
5 (1) proximately caused by
6 (A) its failure to exercise ordinary care; or
7 (B) a health care treatment decision that constitutes a failure to
8 exercise ordinary care made by an employee, agent, ostensible agent, or
9 representative who is acting on behalf of a managed care entity; or
10 (2) resulting from the failure to provide care or treatment covered by
11 the health care plan.
12 (c) This section does not create
13 (1) an obligation on the part of a managed care entity to provide to a
14 covered person care or treatment that is not covered by the health care plan; or
15 (2) civil liability for an employer, an association of employers, a labor
16 organization, or other employer group if the employer, association, labor organization,
17 or group does not make health care treatment decisions.
18 (d) It is a defense to a civil action asserted against a managed care entity if
19 the managed care entity proves by a preponderance of the evidence that it did not
20 control, influence, or participate in the health care treatment decision and did not deny
21 or delay payment for any treatment prescribed or recommended to a covered person
22 by a treating provider.
23 (e) In a civil action against a managed care entity, a finding that a physician
24 or other health care provider is an employee, agent, ostensible agent, or representative
25 of that managed care entity may not be based solely on proof that the physician's or
26 health care provider's name appears in a list of approved physicians or health care
27 providers made available to a covered person under the health care plan of the
28 managed care entity.
29 (f) In this section,
30 (1) "covered person" means a person enrolled in or insured by a health
31 care plan;

1 (2) "health care treatment decision" means
2 (A) a determination made when medical services are actually
3 provided by a health care plan;
4 (B) a decision that affects the quality of the diagnosis, care, or
5 treatment provided to a health care plan's insureds or enrollees; and
6 (C) a decision based on prospective and current review of
7 proposed medical treatment;
8 (3) "managed care entity" has the meaning given in AS 21.07.250;
9 (4) "ordinary care" means care that satisfies reasonable medical
10 standards that prevail in the area in which the person being treated is located.
11 * **Sec. 3.** AS 21 is amended by adding a new chapter to read:
12 **Chapter 07. Regulation of Managed Care Insurance Plans.**
13 **Sec. 21.07.010. Patient and health care provider protection.** (a) A contract
14 between a participating health care provider and a managed care entity that offers a
15 group managed care plan must contain a provision that
16 (1) clearly identifies all health care services to be provided;
17 (2) clearly identifies which health care services are to be provided by
18 a contracting health care provider;
19 (3) clearly identifies and describes each insurance policy used by the
20 group managed care plan to provide identified health care services to a covered person;
21 (4) clearly states the health care provider's rate of compensation;
22 (5) clearly states all ways in which the contract between the health care
23 provider and managed care entity may be terminated; a provision that provides for
24 discretionary termination by either party must apply equitably to both parties;
25 (6) provides that, in the event of a dispute between the parties to the
26 contract, the following procedure must be used before either party may pursue other
27 remedies:
28 (A) an initial meeting at which all parties are present or
29 represented by individuals with full decision-making authority regarding the
30 matters in dispute shall be held within seven working days after the plan
31 receives notice of the dispute or gives notice to the provider, unless the parties

1 otherwise agree in writing to a different schedule;
2 (B) if, within 30 days following the initial meeting, the parties
3 have not resolved the dispute, the dispute shall be submitted to mediation
4 directed by a mediator who is mutually agreeable to the parties and who is not
5 regularly under contract to or employed by either of the parties; each party
6 shall bear its proportionate share of the cost of mediation, including the
7 mediator fees;
8 (C) if, after a period of 60 days following commencement of
9 mediation, the parties are unable to resolve the dispute, either party may submit
10 the dispute to binding arbitration in accordance with (E) of this paragraph;
11 (D) the parties shall agree to negotiate in good faith in the
12 initial meeting and in mediation;
13 (E) after 10 days' written notice to the other party, either party
14 may submit the dispute to final and binding arbitration; binding arbitration shall
15 be held in the judicial district in this state where the services at issue in the
16 dispute were or are to be performed; at the request of either party, an
17 arbitration proceeding may be conducted electronically, including by telephone
18 or video conferencing; and
19 (F) binding arbitration shall be conducted under the rules of the
20 National Health Lawyers Association Alternative Dispute Resolution Project;
21 each party shall be responsible for its own costs and expenses related to the
22 arbitration, including attorney fees, and shall bear a proportionate share of the
23 arbitrator fees; the arbitrator shall be selected by mutual agreement between the
24 parties; the arbitrator shall be a person who is knowledgeable of state law and
25 business practices, an attorney, and a member of the National Academy of
26 Arbitrators or the National Health Lawyers Association;
27 (7) states that a health care provider may not be penalized or the health
28 care provider's contract terminated by the managed care entity because the health care
29 provider acts as an advocate for a covered person in seeking appropriate, medically
30 necessary health care services;
31 (8) protects the ability of a health care provider to communicate openly

1 with a covered person about all appropriate diagnostic testing and treatment options;
2 and

3 (9) defines words in a clear and concise manner.

4 (b) A contract between a participating health care provider and a managed care
5 entity that offers a group managed care plan may not contain a provision that

6 (1) provides financial incentives to the health care provider for
7 withholding covered health care services that are medically necessary;

8 (2) describes the products used by the plan as including all products
9 that are currently offered or that may be offered in the future by the managed care
10 entity; and

11 (3) requires the health care provider to be compensated for health care
12 services performed at the same rate as the health care provider has contracted with
13 another managed care entity.

14 (c) A managed care entity may not enter into a contract with a health care
15 provider that includes an indemnification or hold harmless clause for the acts or
16 conduct of the managed care entity. An indemnification or hold harmless clause
17 entered into in violation of this subsection is void.

18 Sec. 21.07.020. **Required contract provisions for group managed care**
19 **plans.** A group managed care plan must contain

20 (1) a provision that payment for a covered medical procedure that has
21 been preapproved by a managed care entity may not be denied after it has been
22 preapproved;

23 (2) a provision for emergency room services if any coverage is
24 provided for treatment of a medical emergency;

25 (3) a provision that covered health care services be reasonably available
26 in the community in which a covered person resides or that adequate referrals outside
27 the community be available if the health care service is not available in the
28 community; this paragraph is intended to require that a managed care entity contract
29 with a sufficient number of health care providers in each community in which it
30 operates or intends to operate to allow persons covered by the plan to have access to
31 health care services that fall within the standard of care for that community;

1 (4) a provision that any utilization review decision
2 (A) must be made within 72 hours after receiving the necessary
3 claim for payment or request for preapproval for nonemergency situations; for
4 emergency situations, utilization review decisions for care following emergency
5 services must be made as soon as is practicable but in any event no later than
6 24 hours after receiving the request for preapproval or for coverage
7 determination; and
8 (B) to deny, reduce, or terminate a health care benefit or to
9 deny payment for a health care service because that service is not medically
10 necessary shall be made by an employee or agent of the managed care entity
11 who is a licensed health care provider trained in the specialty or subspecialty
12 pertaining to the health care service involved and only after consultation with
13 the covered person's treating health care provider;
14 (5) a provision that provides for an internal appeal mechanism for a
15 covered person who disagrees with a utilization review decision made by a managed
16 care entity; this appeal mechanism must provide for a written decision from the
17 managed care entity within 15 working days from the date an appeal is received;
18 (6) a provision that discloses the existence of the right to an external
19 appeal of a utilization review decision made by a managed care entity; the external
20 appeal shall be as conducted in accordance with AS 21.07.050;
21 (7) a provision that discloses covered items and services, optional
22 supplemental benefits, and benefits relating to and restrictions on nonparticipating
23 provider services;
24 (8) a provision that describes the covered service area, preapproval
25 requirements, and the coverage for clinical trial, experimental, or investigational
26 treatment;
27 (9) a provision describing compensation methods, including assignment
28 of benefits, for health care providers and health care facilities;
29 (10) a provision describing availability of prescription medications or
30 a formulary guide, including specific exclusions; if a formulary guide is made
31 available, the guide must be updated annually; and

1 (11) a provision describing available translation or interpreter services,
2 including audiotape or braille information.
3 **Sec. 21.07.030. Choice of health care provider.** (a) If a managed care entity
4 offers a group health plan that provides for coverage of health care services only if the
5 services are furnished through a network of health care providers that have entered into
6 a contract with the managed care entity, the managed care entity shall also offer a non-
7 network option to enrollees at initial enrollment, as provided under (c) of this section.
8 The non-network option may require that a covered person pay a higher deductible or
9 copayment and a higher premium for the plan if the higher deductible, copayment, or
10 premium results from increased costs caused by the use of a non-network provider.
11 The managed care entity shall provide an actuarial demonstration of the increased costs
12 to the director at the director's request. If the increased costs are not justified, the
13 director shall determine the appropriate costs allowed and determine the appropriate
14 amount of higher deductible, copayment, or premium. This subsection does not apply
15 to an enrollee who is offered non-network coverage through another group health plan
16 or through another managed care entity in the group market.
17 (b) The amount of any additional premium charged by the managed care entity
18 for the additional cost of the creation and maintenance of the option described in (a)
19 of this section and the amount of any additional cost sharing imposed under this option
20 shall be paid by the enrollee unless it is paid by the employer through agreement with
21 the managed care entity.
22 (c) An enrollee may make a change to the health care coverage option
23 provided under this section only during a time period determined by the managed care
24 entity. The time period described in this subsection must occur at least annually.
25 (d) If a managed care entity that offers a group managed care plan requires or
26 provides for a designation by an enrollee of a participating primary care provider, the
27 managed care entity shall permit the enrollee to designate any participating primary
28 care provider that is available to accept the enrollee.
29 (e) Except as provided in this subsection, a managed care entity that offers a
30 group managed care plan shall permit an enrollee to receive medically necessary or
31 appropriate specialty care, subject to appropriate referral procedures, from any qualified

participating health care provider that is available to accept the individual for medical care. This subsection does not apply to specialty care if the managed care entity clearly informs enrollees of the limitations on choice of participating health care providers with respect to medical care. In this subsection,

(1) "appropriate referral procedures" means procedures for referring patients to other health care providers that comply with ethical guidelines established by the American Medical Association;

(2) "specialty care" means care provided by a health care provider with training and experience in treating a particular injury, illness, or condition.

(f) A managed care entity shall notify a covered person when a contract between a health care provider and the managed care entity is terminated for cause.

(g) If a contract between a health care provider and a managed care entity is terminated, a covered person may continue to be treated by that health care provider as provided in this subsection. If a covered person was treated by a provider within the six-month period immediately preceding the date of the termination of the contract between that provider and the managed care entity, the covered person may continue to receive health care services from that provider, and the managed care entity shall continue to treat the provider in all respects as if the contract were still in force. The covered person shall be treated for the purposes of benefit determination or claim payment as if the provider were still under contract with the managed care entity. However, treatment is required to continue only while the group managed care plan remains in effect and

(1) for the period that is the longest of

(A) the end of the current plan year;

(B) the end of the medically necessary treatment for the condition, disease, illness, or injury that the covered person was treated for during that most recent six-month period before the termination of the contract between the provider and the managed care entity; or

(C) six months from the initial treatment by a provider; or

(2) until the end of the medically necessary treatment for the condition, disease, illness, or injury if the person has a terminal condition, disease, illness, or

New Text Underlined [DELETED TEXT BRACKETED]

1 injury; in this paragraph "terminal" means a life expectancy of less than one year.
2 (h) The requirements of this section do not apply to health care services
3 covered by Medicaid.
4 **Sec. 21.07.040. Confidentiality of managed care information.** (a) Medical
5 and financial information in the possession of a managed care entity regarding an
6 applicant or a current or former person covered by a managed care plan is confidential
7 and is not subject to public disclosure.
8 (b) This section does not apply to medical information that is disclosed for
9 research purposes if
10 (1) the individual whose identity is disclosed gives written consent to
11 the disclosure; or
12 (2) the information is released in a form that does not reveal the
13 identity of an individual.
14 **Sec. 21.07.050. External health care appeals.** (a) A managed care entity
15 offering group health insurance coverage shall provide for an external appeal process
16 that meets the requirements of this section in the case of an externally appealable
17 decision for which a timely appeal is made either by the managed care entity or by the
18 enrollee.
19 (b) A managed care entity may condition the use of an external appeal process
20 in the case of an externally appealable decision upon a final decision in an internal
21 review under AS 21.07.020, but only if the decision is made in a timely basis
22 consistent with the deadlines provided under this chapter.
23 (c) A managed care entity
24 (1) may condition the use of an external appeal process upon payment
25 to the managed care entity of a filing fee that does not exceed $25;
26 (2) may not require payment of a filing fee in the case of an enrollee
27 who certifies that the enrollee is indigent;
28 (3) shall refund payment of the filing fee under (1) of this subsection
29 if the recommendation of the external appeal agency is to reverse or modify the denial
30 of a claim for benefits that is the subject of the appeal.
31 (d) Except as provided in this subsection, the external appeal process shall be

1 conducted under a contract between the managed care entity and one or more external
2 appeal agencies that have qualified under AS 21.07.060. The managed care entity
3 shall provide
4 (1) that the selection process among external appeal agencies qualifying
5 under AS 21.07.060 does not create any incentives for external appeal agencies to
6 make a decision in a biased manner;
7 (2) for auditing a sample of decisions by external appeal agencies to
8 assure that decisions are not made in a biased manner; and
9 (3) that all costs of the process, except those incurred by the enrollee
10 or treating professional in support of the appeal, shall be paid by the managed care
11 entity and not by the enrollee; this paragraph does not apply to the imposition of a
12 filing fee under (c) of this section.
13 (e) An external appeal process must include at least the following:
14 (1) a fair, de novo determination based on coverage provided by the
15 plan and by applying terms as defined by the plan; however, nothing in this paragraph
16 may be construed as providing for coverage of items and services for which benefits
17 are specifically excluded under the plan or coverage;
18 (2) an external appeal agency shall determine whether the managed care
19 entity's decision, is in accordance with the medical needs of the patient involved, as
20 determined by the managed care entity, taking into account, as of the time of the
21 managed care entity's decision, the patient's medical needs and any relevant and
22 reliable evidence the agency obtains under (4) of this subsection; if the agency
23 determines the decision is in accordance with the patient's needs, the agency shall
24 affirm the decision and to the extent that the agency determines the decision is not in
25 accordance with the patient's needs, the agency shall reverse or modify the decision;
26 (3) in making a determination, the external appeal agency shall
27 consider, but is not bound by, any language in the plan or coverage document relating
28 to the definitions of the terms "medical necessity," "medically necessary or
29 appropriate," "experimental," "investigational," or similar terms;
30 (4) the external appeal agency shall include among the evidence taken
31 into consideration

1 (A) the decision made by the managed care entity upon internal
2 review under AS 21.07.020 and any guidelines or standards used by the
3 managed care entity in reaching a decision;
4 (B) any personal health and medical information supplied with
5 respect to the individual whose denial of claim for benefits has been appealed:
6 and
7 (C) the opinion of the individual's treating physician or health
8 care provider;
9 (5) the external appeal agency may also take into consideration, but is
10 not limited to considering, the following evidence:
11 (A) the results of studies that meet professionally recognized
12 standards of validity and replicability or that have been published in peer-
13 reviewed journals;
14 (B) the results of professional consensus conferences conducted
15 or financed in whole or in part by one or more government agencies;
16 (C) practice and treatment guidelines prepared or financed in
17 whole or in part by government agencies;
18 (D) government-issued coverage and treatment policies;
19 (E) community standard of care and generally accepted
20 principles of professional medical practice;
21 (F) to the extent that the agency determines it to be free of any
22 conflict of interest, the opinions of individuals who are qualified as experts in
23 one or more fields of health care that are directly related to the matters under
24 appeal; and
25 (G) to the extent that the agency determines it to be free of any
26 conflict of interest, the results of peer reviews conducted by the managed care
27 entity involved;
28 (6) an external appeal agency shall determine
29 (A) whether a denial of a claim for benefits is an externally
30 appealable decision;
31 (B) whether an externally appealable decision involves an

1 expedited appeal; and
2 (C) for purposes of initiating an external review, whether the
3 internal review process has been completed;
4 (7) a party to an externally appealable decision may submit evidence
5 related to the issues in dispute;
6 (8) the managed care entity involved shall provide the external appeal
7 agency with access to information and to provisions of the plan or health insurance
8 coverage relating to the matter of the externally appealable decision, as determined by
9 the external appeal agency; and
10 (9) a determination by the external appeal agency on the decision must
11 (A) be made orally or in writing and, if it is made orally, shall
12 be supplied to the parties in writing as soon as possible;
13 (B) be made in accordance with the medical exigencies of the
14 case involved, but in no event later than 21 working days after the appeal is
15 filed, or, in the case of an expedited appeal, 72 hours after the time of
16 requesting an external appeal of the managed care entity's decision;
17 (C) state, in layperson's language, the basis for the
18 determination, including, if relevant, any basis in the terms or conditions of the
19 plan or coverage; and
20 (D) inform the enrollee of the individual's rights, including any
21 limitation on those rights, to seek further review by the courts of the external
22 appeal determination.
23 (f) If the external appeal agency reverses or modifies the denial of a claim for
24 benefits, the managed care entity shall
25 (1) upon receipt of the determination, authorize benefits in accordance
26 with that determination;
27 (2) take action as may be necessary to provide benefits, including items
28 or services, in a timely manner consistent with the determination; and
29 (3) submit information to the external appeal agency documenting
30 compliance with the agency's determination.
31 (g) A decision of an external appeal agency is binding unless a person who is

1 aggrieved by a final decision of an external appeal agency appeals the decision to the
2 superior court.
3 (h) An appeal of a final decision of an external appeal agency must be filed
4 within six months after the date of the decision of the external appeal agency.
5 (i) In this section, "externally appealable decision"
6 (1) means
7 (A) a denial of a claim for benefits that is based in whole or in
8 part on a decision that the item or service is not medically necessary or
9 appropriate or is investigational or experimental, or in which the decision as to
10 whether a benefit is covered involves a medical judgment; or
11 (B) a failure to meet an applicable deadline for internal review
12 under AS 21.07.020;
13 (2) does not include specific exclusions or express limitations on the
14 amount, duration, or scope of coverage that do not involve medical judgment, or a
15 decision regarding whether an individual is a participant, beneficiary, or enrollee under
16 the plan or coverage.
17 **Sec. 21.07.060. Qualifications of external appeal agencies.** (a) An external
18 appeal agency qualifies to consider external appeals if, with respect to a group health
19 plan, the agency is certified by a qualified private standard-setting organization
20 approved by the director or by a health insurer operating in this state as meeting the
21 requirements imposed under (b) of this section.
22 (b) An external appeal agency is qualified to consider appeals of group health
23 plan health care decisions if the agency meets the following requirements:
24 (1) the agency meets the independence requirements of this section;
25 (2) the agency conducts external appeal activities through a panel of
26 not fewer than three clinical peers; and
27 (3) the agency has sufficient medical, legal, and other expertise and
28 sufficient staffing to conduct external appeal activities for the managed care entity on
29 a timely basis consistent with this chapter.
30 (c) A clinical peer or other entity meets the independence requirements of this
31 section if

1 (1) the peer or entity does not have a familial, financial, or professional
2 relationship with a related party;
3 (2) compensation received by a peer or entity in connection with the
4 external review is reasonable and not contingent on any decision rendered by the peer
5 or entity;
6 (3) the plan and the issuer have no recourse against the peer or entity
7 in connection with the external review; and
8 (4) the peer or entity does not otherwise have a conflict of interest with
9 a related party.
10 (d) In this section, "related party" means
11 (1) with respect to
12 (A) a group health plan or health insurance coverage offered in
13 connection with a plan, the plan or the insurer offering the coverage; or
14 (B) individual health insurance coverage, the insurer offering
15 the coverage, or any plan sponsor, fiduciary, officer, director, or management
16 employee of the plan or issuer;
17 (2) the health care professional that provided the health care involved
18 in the coverage decision;
19 (3) the institution at which the health care involved in the coverage
20 decision is provided;
21 (4) the manufacturer of any drug or other item that was included in the
22 health care involved in the coverage decision; or
23 (5) any other party that, under the regulations that the director may
24 prescribe, is determined by the director to have a substantial interest in the coverage
25 decision.
26 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal
27 agency qualifying under AS 21.07.060 and having a contract with a managed care
28 entity, and a person who is employed by the agency or who furnishes professional
29 services to the agency, may not be held by reason of the performance of any duty,
30 function, or activity required or authorized under this chapter to have violated any
31 criminal law, or to be civilly liable if due care was exercised in the performance of the

1 duty, function or activity and there was no actual malice or gross misconduct in the
2 performance of the duty, function, or activity.
3 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be
4 construed to
5 (1) restrict or limit the right of a managed care entity to include health
6 care services provided by a religious nonmedical provider as health care services
7 covered by the managed care plan;
8 (2) require a managed care entity, when determining coverage for
9 health care services provided by a religious nonmedical provider, to
10 (A) apply medically based eligibility standards;
11 (B) use health care providers to determine access by a covered
12 person;
13 (C) use health care providers in making a decision on an
14 internal or external appeal; or
15 (D) require a covered person to be examined by a health care
16 provider as a condition of coverage; or
17 (3) require a managed care plan to exclude coverage for health care
18 services provided by a religious nonmedical provider because the religious nonmedical
19 provider is not providing medical or other data required from a health care provider
20 if the medical or other data is inconsistent with the religious nonmedical treatment or
21 nursing care being provided.
22 **Sec. 21.07.250. Definitions.** In this chapter,
23 (1) "clinical peer" means a health care provider who is licensed to
24 provide the same or similar health care services and who is trained in the specialty or
25 subspecialty applicable to the health care services that are provided;
26 (2) "clinical trial" means treatment, research, study, or investigation
27 over a period of time of an injury, illness, or medical condition;
28 (3) "emergency room services" means health care services provided by
29 a hospital or other emergency facility after the sudden onset of a medical condition
30 that manifests itself by symptoms of sufficient severity, including severe pain, that the
31 absence of immediate medical attention would reasonably be expected by a prudent

1 person who possesses an average knowledge of health and medicine to result in
2 (A) the placing of the person's health in serious jeopardy;
3 (B) a serious impairment to bodily functions; or
4 (C) a serious dysfunction of a bodily organ or part;
5 (4) "group managed care plan" or "plan" means a group health
6 insurance plan operated by a managed care entity;
7 (5) "health care provider" means a person licensed in this state or
8 another state of the United States to provide health care services;
9 (6) "health care services" means treatment of an individual for an
10 injury, illness, or disability and includes preventative treatment of an injury or illness;
11 (7) "health insurance" has the meaning given in AS 21.12.050(a);
12 (8) "managed care" means a contract given to an individual, family, or
13 group of individuals under which a member is entitled to receive a defined set of
14 health care benefits in exchange for defined consideration and that requires the member
15 to comply with utilization review guide lines; "managed care" does not include
16 Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);
17 (9) "managed care contractor" means a contractor who establishes,
18 operates, or maintains a network of participating health care providers, conducts or
19 arranges for utilization review activities, and contracts with a managed care entity;
20 (10) "managed care entity" means an insurer, a hospital or medical
21 service corporation, a health maintenance organization, an employer or employee
22 health care organization, a managed care contractor that operates a group managed care
23 plan, or a person who has a financial interest in health care services provided to an
24 individual;
25 (11) "medical emergency" means the sudden onset of a medical
26 condition that manifests itself by symptoms of sufficient severity, including severe pain
27 that in the absence of immediate medical attention would reasonably be expected by
28 a prudent person who possesses an average knowledge of health and medicine to result
29 in
30 (A) the placing of the person's health in serious jeopardy;
31 (B) a serious impairment to bodily functions; or

1 (C) a serious dysfunction of any bodily organ or part;
2 (12) "medical necessity" means those health care services or products
3 that a prudent physician would provide to a patient for the purpose of preventing,
4 diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is
5 (A) consistent with generally accepted standards of medical
6 practice;
7 (B) clinically appropriate in terms of type, frequency, extent,
8 site, and duration; and
9 (C) not primarily for the convenience of the patient, physician,
10 or other health care provider;
11 (13) "participating health care provider" means a health care provider
12 who has entered into an agreement with a managed care entity to provide services or
13 supplies to a patient covered by a group managed care plan;
14 (14) "primary care provider" means a health care provider who provides
15 general health care services and does not specialize in treating a single injury, illness,
16 or condition or who provides obstetrical, gynecological, or pediatric health care
17 services;
18 (15) "provider" means a health care provider;
19 (16) "religious nonmedical provider" means a person who does not
20 provide medical care, but who provides only religious nonmedical treatment or nursing
21 care for an illness or injury;
22 (17) "utilization review" means a system of reviewing the medical
23 necessity, appropriateness, or quality of health care services and supplies provided
24 under a group managed care plan using specified guidelines, including preadmission
25 certification, the application of practice guidelines, continued stay review, discharge
26 planning, preauthorization of ambulatory procedures, and retrospective review;
27 (18) "working day" means a day of the week that is not a Saturday,
28 Sunday, or a holiday.
29 * **Sec. 4.** AS 21.36.125 is amended by adding a new paragraph to read:
30 (16) violate a provision contained in AS 21.07.
31 * **Sec. 5.** AS 21.42 is amended by adding new sections to read:

1 **Sec 21.42.390. Required health insurance coverage provisions.** (a) A
2 health care insurer may not include in a health care insurance plan or contract a
3 provision that restricts a covered person's right to receive full information from the
4 person's health care provider regarding the care or treatment options that the health
5 care provider believes are in the best interests of the person.
6 (b) A health care insurer may not deny, reduce, or terminate health care
7 payments or deny payment for a health care service because that service is not
8 medically necessary unless that decision is made by an employee or agent of the
9 insurer who is a licensed health care provider trained in that specialty or subspecialty
10 pertaining to that health care service involved and only after consultation with the
11 covered person's treating health care provider.
12 (c) An insurer may not deny coverage, cancel a health insurance policy or
13 subscriber contract, or otherwise take action against an insured person or a health care
14 provider because that person has asserted a right described in this section.
15 (d) A covered person may bring a civil action against a health care insurer to
16 enforce the person's rights under this section.
17 (e) In this section, "health care provider" means a person licensed in this state
18 or another state of the United States to provide health care services.
19 **Sec 21.42.392. Requirements relating to dental care coverage provisions.**
20 (a) A health care insurer who provides coverage for dental care may not include in
21 the health care insurance plan or contract a provision that
22 (1) prohibits a covered person from obtaining dental care services from
23 a dentist of the person's choice, including a specialist;
24 (2) restricts a covered person's right to receive full information from
25 the person's dentist regarding the care or treatment options that the dentist believes are
26 in the best interests of the person.
27 (b) A health care insurance plan or contract that provides coverage for dental
28 services that allows the health care insurer to review a treatment plan or conduct a
29 utilization review must contain a provision that a treatment plan review or utilization
30 review relating to dental care for a covered person receiving treatment in this state
31 must be conducted by a dentist.

1 (c) A health care insurer may not
2 (1) directly or indirectly reimburse a covered person at a different rate
3 because of the person's choice of a dentist;
4 (2) deny coverage, cancel a health care insurance plan or contract, or
5 otherwise take action against a covered person or a dentist because the person has
6 asserted a right described in this section.
7 (d) A covered person may bring a civil action against a health care insurer to
8 enforce the person's rights under this section.
9 (e) In this section, "dentist" means a person licensed in this state to practice
10 dentistry.
11 * **Sec. 6.** AS 21.86.150(j) is repealed.
12 * **Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section
13 to read:
14 INDIRECT COURT RULE AMENDMENT. AS 21.07.050(h), as enacted by sec. 3
15 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by
16 providing that an appeal from a decision of an external appeal agency must be filed within
17 six months of the decision of the external appeal agency.
18 * **Sec. 8.** The uncodified law of the State of Alaska is amended by adding a new section
19 to read:
20 CONDITIONAL EFFECT. AS 21.07.050(h), as enacted by sec. 3 of this Act, takes
21 effect only if sec. 7 of this Act receives the two-thirds majority vote of each house required
22 by art. IV, sec. 15, Constitution of the State of Alaska.
23 * **Sec. 9.** This Act takes effect July 1, 2000.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM April 7, 2000

SUBJECT: Managed care - (CSHB 211(JUD))

TO: Representative Pete Kott
Attn: Lesil

FROM: Michael F. Ford
Legislative Counsel

The draft you requested is attached. I have added the new provision regarding "medical necessity" as a new paragraph 2 in Sec. 21.07.020, beginning on page 3, line 25. This provision raises issues regarding other existing provisions in the bill, however. I believe it is necessary to also change Sec. 21.07.020(1), (5)(B) and (6)(B). These are provisions that also involve determinations regarding "medical necessity" and need to be amended to avoid conflicts or duplications. You could simply remove the conflicting provisions, but this may be a change that is too drastic. In short there is no quick fix for this situation. One approach you may consider is to make Sec. 21.07.020(1) contingent on compliance with Sec. 21.07.020(2), and simply remove Sec. 21.07.020(5)(B) and (6)(B), but that still leaves the issue of "utilization review". Utilization review, as defined in Sec. 21.07.250, includes a determination of "medical necessity". You could specifically exclude "medical necessity" from the utilization review process and leave this issue to the independent review organization. Again this may require other adjustments to the bill.

Let me know what you decide.

MFF:glc
00-165.glc

1-LS0472\V
Ford
4/7/00

CS FOR HOUSE BILL NO. 211(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): **REPRESENTATIVE ROKEBERG BY REQUEST**

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulation of managed care insurance plans; amending Rule**
2 **602(b), Alaska Rules of Appellate Procedure; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new
5 section to read:
6 SHORT TITLE. Section 2 of this Act may be known as the Alaska Patients' Bill of
7 Rights.
8 * **Sec. 2.** AS 21 is amended by adding a new chapter to read:
9 **Chapter 07. Regulation of Managed Care Insurance Plans.**
10 **Sec. 21.07.010. Patient and health care provider protection.** (a) A contract
11 between a participating health care provider and a managed care entity that offers a
12 group managed care plan must contain a provision that
13 (1) provides for a reasonable mechanism to identify all health care
14 services to be provided by the managed care entity;

1 (2) clearly states or references an attachment that states the health care
2 provider's rate of compensation;
3 (3) clearly states all ways in which the contract between the health care
4 provider and managed care entity may be terminated; a provision that provides for
5 discretionary termination by either party must apply equitably to both parties;
6 (4) provides that, in the event of a dispute between the parties to the
7 contract, a fair, prompt, and mutual dispute resolution process must be used; at a
8 minimum, the process must provide
9 (A) for an initial meeting at which all parties are present or
10 represented by individuals with authority regarding the matters in dispute; the
11 meeting shall be held within 10 working days after the plan receives written
12 notice of the dispute or gives written notice to the provider, unless the parties
13 otherwise agree in writing to a different schedule;
14 (B) that if, within 30 days following the initial meeting, the
15 parties have not resolved the dispute, the dispute shall be submitted to
16 mediation directed by a mediator who is mutually agreeable to the parties and
17 who is not regularly under contract to or employed by either of the parties;
18 each party shall bear its proportionate share of the cost of mediation, including
19 the mediator fees;
20 (C) that if, after a period of 60 days following commencement
21 of mediation, the parties are unable to resolve the dispute, either party may
22 seek other relief allowed by law;
23 (D) that the parties shall agree to negotiate in good faith in the
24 initial meeting and in mediation;
25 (5) states that a health care provider may not be penalized or the health
26 care provider's contract terminated by the managed care entity because the health care
27 provider acts as an advocate for a covered person in seeking appropriate, medically
28 necessary health care services;
29 (6) protects the ability of a health care provider to communicate openly
30 with a covered person about all appropriate diagnostic testing and treatment options;
31 and

1 (7) defines words in a clear and concise manner.
2 (b) A contract between a participating health care provider and a managed care
3 entity that offers a group managed care plan may not contain a provision that
4 (1) has as its predominant purpose the creation of direct financial
5 incentives to the health care provider for withholding covered health care services that
6 are medically necessary; nothing in this paragraph shall be construed to prohibit a
7 contract between a participating health care provider and a managed care entity from
8 containing incentives for efficient management of the utilization and cost of covered
9 health care services;
10 (2) requires the provider to contract for all products that are currently
11 offered or that may be offered in the future by the managed care entity; and
12 (3) requires the health care provider to be compensated for health care
13 services performed at the same rate as the health care provider has contracted with
14 another managed care entity.
15 (c) A managed care entity may not enter into a contract with a health care
16 provider that requires the provider to indemnify or hold harmless the managed care
17 entity for the acts [handwritten: or conduct] of the managed care entity. An indemnification or hold harmless
18 clause entered into in violation of this subsection is void.
19 **Sec. 21.07.020. Required contract provisions for group managed care**
20 **plans.** A group managed care plan must contain
21 (1) a provision that preauthorization for a covered medical procedure
22 on the basis of medical necessity may not be retroactively denied unless the
23 preauthorization is based on materially incomplete or inaccurate information provided
24 by or on behalf of the provider;
25 (2) a provision that a determination regarding the medical necessity or
26 appropriateness of health care services for an enrollee or the application of managed
27 care plan provisions to an enrollee must be made by medical reviewers from an
28 independent review organization; a determination by a medical reviewer shall be based
29 on the medical reviewer's expert medical judgment, after consideration of relevant
30 medical, scientific, and cost-effective evidence, and medical standards of practice in
31 this state; except as provided in this paragraph, the independent review organization

1 must ensure that a determination is consistent with the scope of covered benefits as
2 outlined in the managed care plan; a medical reviewer may override the managed care
3 plan's standard of medical necessity or appropriateness of health care services if the
4 standard is determined by the medical reviewer to be unreasonable or inconsistent with
5 sound, evidence-based medical practice;
6 (3) a provision for emergency room services if any coverage is
7 provided for treatment of a medical emergency;
8 (4) a provision that covered health care services be reasonably available
9 in the community in which a covered person resides or that, if referrals are required
10 by the plan, adequate referrals outside the community be available if the health care
11 service is not available in the community;
12 (5) a provision that any utilization review decision
13 (A) must be made within 72 hours after receiving the request
14 for preapproval for nonemergency situations; for emergency situations,
15 utilization review decisions for care following emergency services must be
16 made as soon as is practicable but in any event no later than 24 hours after
17 receiving the request for preapproval or for coverage determination; and
18 (B) to deny, reduce, or terminate a health care benefit or to
19 deny payment for a health care service because that service is not medically
20 necessary shall be made by an employee or agent of the managed care entity
21 who is a licensed health care provider;
22 (6) a provision that provides for an internal appeal mechanism for a
23 covered person who disagrees with a utilization review decision made by a managed
24 care entity; except as provided under (7) of this section, this appeal mechanism must
25 provide for a written decision
26 (A) from the managed care entity within 18 working days after
27 the date written notice of an appeal is received; and
28 (B) on the appeal by an employee or agent of the managed care
29 entity who holds the same professional license as the health care provider who
30 is treating the covered person;
31 (7) a provision that provides for an internal appeal mechanism for a

1 covered person who disagrees with a utilization review decision made by a managed
2 care entity in any case in which delay would, in the written opinion of the treating
3 provider, jeopardize the covered person's life or materially jeopardize the covered
4 person's health; the managed care entity shall
5 (A) decide an appeal described in this paragraph within 72
6 hours after receiving the appeal; and
7 (B) provide for a written decision on the appeal by an employee
8 or agent of the managed care entity who holds the same professional license
9 as the health care provider who is treating the covered person;
10 (8) a provision that discloses the existence of the right to an external
11 appeal of a utilization review decision made by a managed care entity; the external
12 appeal shall be as conducted in accordance with AS 21.07.050;
13 (9) a provision that discloses covered benefits, optional supplemental
14 benefits, and benefits relating to and restrictions on nonparticipating provider services;
15 (10) a provision that describes the preapproval requirements and
16 whether clinical trials or experimental or investigational treatment are covered;
17 (11) a provision describing a mechanism for assignment of benefits for
18 health care providers and payment of benefits;
19 (12) a provision describing availability of prescription medications or
20 a formulary guide, and whether medications not listed are excluded; if a formulary
21 guide is made available, the guide must be updated annually; and
22 (13) a provision describing available translation or interpreter services,
23 including audiotape or braille information.
24 **Sec. 21.07.030. Choice of health care provider.** (a) If a managed care entity
25 offers a group health plan that provides for coverage of health care services only if the
26 services are furnished through a network of health care providers that have entered into
27 a contract with the managed care entity, the managed care entity shall also offer a non-
28 network option to enrollees at initial enrollment, as provided under (c) of this section.
29 The non-network option may require that a covered person pay a higher deductible,
30 copayment, or premium for the plan if the higher deductible, copayment, or premium
31 results from increased costs caused by the use of a non-network provider. The

1 managed care entity shall provide an actuarial demonstration of the increased costs to
2 the director at the director's request. If the increased costs are not justified, the
3 director shall determine the appropriate costs allowed and determine the appropriate
4 amount of higher deductible, copayment, or premium. This subsection does not apply
5 to an enrollee who is offered non-network coverage through another group health plan
6 or through another managed care entity in the group market.
7 (b) The amount of any additional premium charged by the managed care entity
8 for the additional cost of the creation and maintenance of the option described in (a)
9 of this section and the amount of any additional cost sharing imposed under this option
10 shall be paid by the enrollee unless it is paid by the employer through agreement with
11 the managed care entity.
12 (c) An enrollee may make a change to the health care coverage option
13 provided under this section only during a time period determined by the managed care
14 entity. The time period described in this subsection must occur at least annually.
15 (d) If a managed care entity that offers a group managed care plan requires or
16 provides for a designation by an enrollee of a participating primary care provider, the
17 managed care entity shall permit the enrollee to designate any participating primary
18 care provider that is available to accept the enrollee.
19 (e) Except as provided in this subsection, a managed care entity that offers a
20 group managed care plan shall permit an enrollee to receive medically necessary or
21 appropriate specialty care, subject to appropriate referral procedures, from any qualified
22 participating health care provider that is available to accept the individual for medical
23 care. This subsection does not apply to specialty care if the managed care entity
24 clearly informs enrollees of the limitations on choice of participating health care
25 providers with respect to medical care. In this subsection,
26 (1) "appropriate referral procedures" means procedures for referring
27 patients to other health care providers as set out in the applicable member contract and
28 as described under (a) of this section;
29 (2) "specialty care" means care provided by a health care provider with
30 training and experience in treating a particular injury, illness, or condition.
31 (f) If a contract between a health care provider and a managed care entity is

1 terminated, a covered person may continue to be treated by that health care provider
2 as provided in this subsection. If a covered person is pregnant or being actively
3 treated by a provider on the date of the termination of the contract between that
4 provider and the managed care entity, the covered person may continue to receive
5 health care services from that provider as provided in this subsection, and the contract
6 between the managed care entity and the provider shall remain in force with respect
7 to the continuing treatment. The covered person shall be treated for the purposes of
8 benefit determination or claim payment as if the provider were still under contract with
9 the managed care entity. However, treatment is required to continue only while the
10 group managed care plan remains in effect and
11 (1) for the period that is the longest of the following:
12 (A) the end of the current plan year;
13 (B) up to 90 days after the termination date, if the event
14 triggering the right to continuing treatment is part of an ongoing course of
15 treatment; or
16 (C) through completion of postpartum care, if the covered
17 person is in the second trimester of pregnancy on the date of termination; or
18 (2) until the end of the medically necessary treatment for the condition,
19 disease, illness, or injury if the person has a terminal condition, disease, illness, or
20 injury; in this paragraph, "terminal" means a life expectancy of less than one year.
21 (g) The requirements of this section do not apply to health care services
22 covered by Medicaid.
23 **Sec. 21.07.040. Confidentiality of managed care information.** (a) Medical
24 and financial information in the possession of a managed care entity regarding an
25 applicant or a current or former person covered by a managed care plan is confidential
26 and is not subject to public disclosure.
27 (b) This section does not apply to medical information that is disclosed if
28 (1) the individual whose identity is disclosed gives written consent to
29 the disclosure;
30 (2) the information is disclosed for research
31 (A) that is subject to federal law and regulations protecting the

1 rights and welfare of research participants; or
2 (B) using health information that protects the confidentiality of
3 participants by coding or encryption of information that would otherwise
4 identify the patient;
5 (3) the information is disclosed for purposes of obtaining
6 reimbursement under health insurance;
7 (4) the information is disclosed at the written request of the covered
8 person;
9 (5) the disclosure is required by law.
10 **Sec. 21.07.050. External health care appeals.** (a) A managed care entity
11 offering group health insurance coverage shall provide for an external appeal process
12 that meets the requirements of this section in the case of an externally appealable
13 decision for which a timely appeal is made in writing either by the managed care
14 entity or by the enrollee.
15 (b) A managed care entity may condition the use of an external appeal process
16 in the case of an externally appealable decision upon a final decision in an internal
17 appeal under AS 21.07.020, but only if the decision is made in a timely basis
18 consistent with the deadlines provided under this chapter.
19 (c) Except as provided in this subsection, the external appeal process shall be
20 conducted under a contract between the managed care entity and one or more external
21 appeal agencies that have qualified under AS 21.07.060. The managed care entity
22 shall provide
23 (1) that the selection process among external appeal agencies qualifying
24 under AS 21.07.060 does not create any incentives for external appeal agencies to
25 make a decision in a biased manner;
26 (2) for auditing a sample of decisions by external appeal agencies to
27 assure that decisions are not made in a biased manner; and
28 (3) that all costs of the process, except those incurred by the enrollee
29 or treating professional in support of the appeal, shall be paid by the managed care
30 entity and not by the enrollee.
31 (d) An external appeal process must include at least the following:

1 (1) a fair, de novo determination based on coverage provided by the
2 plan and by applying terms as defined by the plan; however, nothing in this paragraph
3 may be construed as providing for coverage of items and services for which benefits
4 are excluded under the plan or coverage;
5 (2) an external appeal agency shall determine whether the managed care
6 entity's decision is (A) in accordance with the medical needs of the patient involved,
7 as determined by the managed care entity, taking into account, as of the time of the
8 managed care entity's decision, the patient's medical needs and any relevant and
9 reliable evidence the agency obtains under (3) of this subsection, and (B) in
10 accordance with the scope of the covered benefits under the plan; if the agency
11 determines the decision complies with this paragraph, the agency shall affirm the
12 decision, and, to the extent that the agency determines the decision is not in
13 accordance with this paragraph, the agency shall reverse or modify the decision;
14 (3) the external appeal agency shall include among the evidence taken
15 into consideration
16 (A) the decision made by the managed care entity upon internal
17 appeal under AS 21.07.020 and any guidelines or standards used by the
18 managed care entity in reaching a decision;
19 (B) any personal health and medical information supplied with
20 respect to the individual whose denial of claim for benefits has been appealed;
21 (C) the opinion of the individual's treating physician or health
22 care provider; and
23 (D) the group managed care plan;
24 (4) the external appeal agency may also take into consideration the
25 following evidence:
26 (A) the results of studies that meet professionally recognized
27 standards of validity and replicability or that have been published in peer-
28 reviewed journals;
29 (B) the results of professional consensus conferences conducted
30 or financed in whole or in part by one or more government agencies;
31 (C) practice and treatment guidelines prepared or financed in

1 whole or in part by government agencies;
2 (D) government-issued coverage and treatment policies;
3 (E) generally accepted principles of professional medical
4 practice;
5 (F) to the extent that the agency determines it to be free of any
6 conflict of interest, the opinions of individuals who are qualified as experts in
7 one or more fields of health care that are directly related to the matters under
8 appeal;
9 (G) to the extent that the agency determines it to be free of any
10 conflict of interest, the results of peer reviews conducted by the managed care
11 entity involved;
12 (H) the community standard of care; and
13 (I) anomalous utilization patterns;
14 (5) an external appeal agency shall determine
15 (A) whether a denial of a claim for benefits is an externally
16 appealable decision;
17 (B) whether an externally appealable decision involves an
18 expedited appeal; and
19 (C) for purposes of initiating an external review, whether the
20 internal appeal process has been completed;
21 (6) a party to an externally appealable decision may submit evidence
22 related to the issues in dispute;
23 (7) the managed care entity involved shall provide the external appeal
24 agency with access to information and to provisions of the plan or health insurance
25 coverage relating to the matter of the externally appealable decision, as determined by
26 the external appeal agency; and
27 (8) a determination by the external appeal agency on the decision must
28 (A) be made orally or in writing and, if it is made orally, shall
29 be supplied to the parties in writing as soon as possible;
30 (B) be made in accordance with the medical exigencies of the
31 case involved, but in no event later than 21 working days after the appeal is

1 filed, or, in the case of an expedited appeal, 72 hours after the time of
2 requesting an external appeal of the managed care entity's decision;
3 (C) state, in layperson's language, the basis for the
4 determination, including, if relevant, any basis in the terms or conditions of the
5 plan or coverage; and
6 (D) inform the enrollee of the individual's rights, including any
7 time limits, to seek further review by the courts of the external appeal
8 determination.
9 (e) If the external appeal agency reverses or modifies the denial of a claim for
10 benefits, the managed care entity shall
11 (1) upon receipt of the determination, authorize benefits in accordance
12 with that determination;
13 (2) take action as may be necessary to provide benefits, including items
14 or services, in a timely manner consistent with the determination; and
15 (3) submit information to the external appeal agency documenting
16 compliance with the agency's determination.
17 (f) A decision of an external appeal agency is binding unless a person who is
18 aggrieved by a final decision of an external appeal agency appeals the decision to the
19 superior court.
20 (g) An appeal of a final decision of an external appeal agency must be filed
21 within six months after the date of the decision of the external appeal agency.
22 (h) In this section, "externally appealable decision"
23 (1) means
24 (A) a denial of a claim for benefits that is based in whole or in
25 part on a decision that the item or service is not medically necessary or
26 appropriate or is investigational or experimental, or in which the decision as to
27 whether a benefit is covered involves a medical judgment; or
28 (B) a denial that is based on a failure to meet an applicable
29 deadline for internal appeal under AS 21.07.020;
30 (2) does not include a decision based on specific exclusions or express
31 limitations on the amount, duration, or scope of coverage that do not involve medical

1 judgment, or a decision regarding whether an individual is a participant, beneficiary,
2 or enrollee under the plan or coverage.
3 **Sec. 21.07.060. Qualifications of external appeal agencies.** (a) An external
4 appeal agency qualifies to consider external appeals if, with respect to a group health
5 plan, the agency is certified by a qualified private standard-setting organization
6 approved by the director or by a health insurer operating in this state as meeting the
7 requirements imposed under (b) of this section.
8 (b) An external appeal agency is qualified to consider appeals of group health
9 plan health care decisions if the agency meets the following requirements:
10 (1) the agency meets the independence requirements of this section;
11 (2) the agency conducts external appeal activities through a panel of
12 two clinical peers, unless otherwise agreed to by both parties; and
13 (3) the agency has sufficient medical, legal, and other expertise and
14 sufficient staffing to conduct external appeal activities for the managed care entity on
15 a timely basis consistent with this chapter.
16 (c) A clinical peer or other entity meets the independence requirements of this
17 section if
18 (1) the peer or entity does not have a familial, financial, or professional
19 relationship with a related party;
20 (2) compensation received by a peer or entity in connection with the
21 external review is reasonable and not contingent on any decision rendered by the peer
22 or entity;
23 (3) the plan and the issuer have no recourse against the peer or entity
24 in connection with the external review; and
25 (4) the peer or entity does not otherwise have a conflict of interest with
26 a related party.
27 (d) In this section, "related party" means
28 (1) with respect to
29 (A) a group health plan or health insurance coverage offered in
30 connection with a plan, the plan or the insurer offering the coverage; or
31 (B) individual health insurance coverage, the insurer offering

New Text Underlined [DELETED TEXT BRACKETED]

1 the coverage, or any plan sponsor, fiduciary, officer, director, or management
2 employee of the plan or issuer;
3 (2) the health care professional that provided the health care involved
4 in the coverage decision;
5 (3) the institution at which the health care involved in the coverage
6 decision is provided;
7 (4) the manufacturer of any drug or other item that was included in the
8 health care involved in the coverage decision;
9 (5) the covered person; or
10 (6) any other party that, under the regulations that the director may
11 prescribe, is determined by the director to have a substantial interest in the coverage
12 decision.
13 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal
14 agency qualifying under AS 21.07.060 and having a contract with a managed care
15 entity, and a person who is employed by the agency or who furnishes professional
16 services to the agency, may not be held by reason of the performance of any duty,
17 function, or activity required or authorized under this chapter to have violated any
18 criminal law, or to be civilly liable if due care was exercised in the performance of the
19 duty, function or activity and there was no actual malice or gross misconduct in the
20 performance of the duty, function, or activity.
21 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be
22 construed to
23 (1) restrict or limit the right of a managed care entity to include health
24 care services provided by a religious nonmedical provider as health care services
25 covered by the managed care plan;
26 (2) require a managed care entity, when determining coverage for
27 health care services provided by a religious nonmedical provider, to
28 (A) apply medically based eligibility standards;
29 (B) use health care providers to determine access by a covered
30 person;
31 (C) use health care providers in making a decision on an

1 internal or external appeal; or
2 (D) require a covered person to be examined by a health care
3 provider as a condition of coverage; or
4 (3) require a managed care plan to exclude coverage for health care
5 services provided by a religious nonmedical provider because the religious nonmedical
6 provider is not providing medical or other data required from a health care provider
7 if the medical or other data is inconsistent with the religious nonmedical treatment or
8 nursing care being provided.
9 **Sec. 21.07.250. Definitions.** In this chapter,
10 (1) "clinical peer" means a health care provider who is licensed to
11 provide the same or similar health care services and who is trained in the specialty or
12 subspecialty applicable to the health care services that are provided;
13 (2) "clinical trial" means treatment, research, study, or investigation
14 over a period of time of an injury, illness, or medical condition;
15 (3) "emergency room services" means health care services provided by
16 a hospital or other emergency facility after the sudden onset of a medical condition
17 that manifests itself by symptoms of sufficient severity, including severe pain, that the
18 absence of immediate medical attention would reasonably be expected by a prudent
19 person who possesses an average knowledge of health and medicine to result in
20 (A) the placing of the person's health in serious jeopardy;
21 (B) a serious impairment to bodily functions; or
22 (C) a serious dysfunction of a bodily organ or part;
23 (4) "group managed care plan" or "plan" means a group health
24 insurance plan operated by a managed care entity;
25 (5) "health care provider" means a person licensed in this state or
26 another state of the United States to provide health care services;
27 (6) "health care services" means treatment of an individual for an
28 injury, illness, or disability and includes preventative treatment of an injury or illness;
29 (7) "health insurance" has the meaning given in AS 21.12.050(a);
30 (8) "managed care" means a contract given to an individual, family, or
31 group of individuals under which a member is entitled to receive a defined set of

1 health care benefits in exchange for defined consideration and that requires the member
2 to comply with utilization review guide lines; "managed care" does not include
3 Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);
4 (9) "managed care contractor" means a contractor who establishes,
5 operates, or maintains a network of participating health care providers, conducts or
6 arranges for utilization review activities, and contracts with a managed care entity;
7 (10) "managed care entity" means an insurer, a hospital or medical
8 service corporation, a health maintenance organization, an employer or employee
9 health care organization, a managed care contractor that operates a group managed care
10 plan, or a person who has a financial interest in health care services provided to an
11 individual;
12 (11) "medical emergency" means the sudden onset of a medical
13 condition that manifests itself by symptoms of sufficient severity, including severe pain
14 that in the absence of immediate medical attention would reasonably be expected by
15 a prudent person who possesses an average knowledge of health and medicine to result
16 in
17 (A) the placing of the person's health in serious jeopardy;
18 (B) a serious impairment to bodily functions; or
19 (C) a serious dysfunction of any bodily organ or part;
20 (12) "participating health care provider" means a health care provider
21 who has entered into an agreement with a managed care entity to provide services or
22 supplies to a patient covered by a group managed care plan;
23 (13) "primary care provider" means a health care provider who provides
24 general health care services and does not specialize in treating a single injury, illness,
25 or condition or who provides obstetrical, gynecological, or pediatric health care
26 services;
27 (14) "provider" means a health care provider;
28 (15) "religious nonmedical provider" means a person who does not
29 provide medical care, but who provides only religious nonmedical treatment or nursing
30 care for an illness or injury;
31 (16) "utilization review" means a system of reviewing the medical

1 necessity, appropriateness, or quality of health care services and supplies provided
2 under a group managed care plan using specified guidelines, including preadmission
3 certification, the application of practice guidelines, continued stay review, discharge
4 planning, preauthorization of ambulatory procedures, and retrospective review;
5 (17) "working day" means a day of the week that is not a Saturday,
6 Sunday, or a holiday.
7 * **Sec. 3.** AS 21.36.125 is amended by adding a new paragraph to read:
8 (16) violate a provision contained in AS 21.07.
9 * **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section
10 to read:
11 INDIRECT COURT RULE AMENDMENT. AS 21.07.050(g), as enacted by sec. 2
12 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by
13 providing that an appeal from a decision of an external appeal agency must be filed within
14 six months of the decision of the external appeal agency.
15 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section
16 to read:
17 CONDITIONAL EFFECT. AS 21.07.050(g), as enacted by sec. 2 of this Act, takes
18 effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required
19 by art. IV, sec. 15, Constitution of the State of Alaska.
20 * **Sec. 6.** This Act takes effect July 1, 2001.

1-LS0472\S
Ford
4/5/00

CS FOR HOUSE BILL NO. 211( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulation of managed care insurance plans; amending Rule**
2 **602(b), Alaska Rules of Appellate Procedure; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new
5 section to read:
6 SHORT TITLE. Section 2 of this Act may be known as the Alaska Patients' Bill of
7 Rights.
8 * **Sec. 2.** AS 21 is amended by adding a new chapter to read:
9 **Chapter 07. Regulation of Managed Care Insurance Plans.**
10 **Sec. 21.07.010. Patient and health care provider protection.** (a) A contract
11 between a participating health care provider and a managed care entity that offers a
12 group managed care plan must contain a provision that
13 (1) provides for a reasonable mechanism to identify all health care
14 services to be provided by the managed care entity;

New Text Underlined [DELETED TEXT BRACKETED]

1 (2) clearly states or references an attachment that states the health care
2 provider's rate of compensation;
3 (3) clearly states all ways in which the contract between the health care
4 provider and managed care entity may be terminated; a provision that provides for
5 discretionary termination by either party must apply equitably to both parties;
6 (4) provides that, in the event of a dispute between the parties to the
7 contract, a fair, prompt, and mutual dispute resolution process must be used; at a
8 minimum, the process must provide
9 (A) for an initial meeting at which all parties are present or
10 represented by individuals with authority regarding the matters in dispute; the
11 meeting shall be held within 10 working days after the plan receives written
12 notice of the dispute or gives written notice to the provider, unless the parties
13 otherwise agree in writing to a different schedule;
14 (B) that if, within 30 days following the initial meeting, the
15 parties have not resolved the dispute, the dispute shall be submitted to
16 mediation directed by a mediator who is mutually agreeable to the parties and
17 who is not regularly under contract to or employed by either of the parties;
18 each party shall bear its proportionate share of the cost of mediation, including
19 the mediator fees;
20 (C) that if, after a period of 60 days following commencement
21 of mediation, the parties are unable to resolve the dispute, either party may
22 seek other relief allowed by law;
23 (D) that the parties shall agree to negotiate in good faith in the
24 initial meeting and in mediation;
25 (5) states that a health care provider may not be penalized or the health
26 care provider's contract terminated by the managed care entity because the health care
27 provider acts as an advocate for a covered person in seeking appropriate, medically
28 necessary health care services;
29 (6) protects the ability of a health care provider to communicate openly
30 with a covered person about all appropriate diagnostic testing and treatment options;
31 and

1 (7) defines words in a clear and concise manner.

2 (b) A contract between a participating health care provider and a managed care
3 entity that offers a group managed care plan may not contain a provision that

4 (1) has as its predominant purpose the creation of direct financial
5 incentives to the health care provider for withholding covered health care services that
6 are medically necessary; nothing in this paragraph shall be construed to prohibit a
7 contract between a participating health care provider and a managed care entity from
8 containing incentives for efficient management of the utilization and cost of covered
9 health care services;

10 (2) requires the provider to contract for all products that are currently
11 offered or that may be offered in the future by the managed care entity; and

12 (3) requires the health care provider to be compensated for health care
13 services performed at the same rate as the health care provider has contracted with
14 another managed care entity.

15 (c) A managed care entity may not enter into a contract with a health care
16 provider that requires the provider to indemnify or hold harmless the managed care
17 entity for the acts [OR conduct] of the managed care entity. An indemnification or hold harmless
18 clause entered into in violation of this subsection is void.

19 **Sec. 21.07.020. Required contract provisions for group managed care**
20 **plans.** A group managed care plan must contain

21 (1) a provision that preauthorization for a covered medical procedure
22 on the basis of medical necessity may not be retroactively denied unless the
23 preauthorization is based on materially incomplete or inaccurate information provided
24 by or on behalf of the provider;

25 (2) a provision for emergency room services if any coverage is
26 provided for treatment of a medical emergency;

27 (3) a provision that covered health care services be reasonably available
28 in the community in which a covered person resides or that, if referrals are required
29 by the plan, adequate referrals outside the community be available if the health care
30 service is not available in the community;

31 (4) a provision that any utilization review decision

1 (A) must be made within 72 hours after receiving the request
2 for preapproval for nonemergency situations; for emergency situations,
3 utilization review decisions for care following emergency services must be
4 made as soon as is practicable but in any event no later than 24 hours after
5 receiving the request for preapproval or for coverage determination; and
6 (B) to deny, reduce, or terminate a health care benefit or to
7 deny payment for a health care service because that service is not medically
8 necessary shall be made by an employee or agent of the managed care entity
9 who is a licensed health care provider;
10 (5) a provision that provides for an internal appeal mechanism for a
11 covered person who disagrees with a utilization review decision made by a managed
12 care entity; except as provided under (6) of this section, this appeal mechanism must
13 provide for a written decision
14 (A) from the managed care entity within 18 working days after
15 the date written notice of an appeal is received; and
16 (B) on the appeal by an employee or agent of the managed care
17 entity who holds the same professional license as the health care provider who
18 is treating the covered person;
19 (6) a provision that provides for an internal appeal mechanism for a
20 covered person who disagrees with a utilization review decision made by a managed
21 care entity in any case in which delay would, in the written opinion of the treating
22 provider, jeopardize the covered person's life or materially jeopardize the covered
23 person's health; the managed care entity shall
24 (A) decide an appeal described in this paragraph within 72
25 hours after receiving the appeal; and
26 (B) provide for a written decision on the appeal by an employee
27 or agent of the managed care entity who holds the same professional license
28 as the health care provider who is treating the covered person;
29 (7) a provision that discloses the existence of the right to an external
30 appeal of a utilization review decision made by a managed care entity; the external
31 appeal shall be as conducted in accordance with AS 21.07.050;

1 (8) a provision that discloses covered benefits, optional supplemental
2 benefits, and benefits relating to and restrictions on nonparticipating provider services;
3 (9) a provision that describes the preapproval requirements and whether
4 clinical trials or experimental or investigational treatment are covered;
5 (10) a provision describing a mechanism for assignment of benefits for
6 health care providers and payment of benefits;
7 (11) a provision describing availability of prescription medications or
8 a formulary guide, and whether medications not listed are excluded; if a formulary
9 guide is made available, the guide must be updated annually; and
10 (12) a provision describing available translation or interpreter services,
11 including audiotape or braille information.
12 **Sec. 21.07.030. Choice of health care provider.** (a) If a managed care entity
13 offers a group health plan that provides for coverage of health care services only if the
14 services are furnished through a network of health care providers that have entered into
15 a contract with the managed care entity, the managed care entity shall also offer a non-
16 network option to enrollees at initial enrollment, as provided under (c) of this section.
17 The non-network option may require that a covered person pay a higher deductible,
18 copayment, or premium for the plan if the higher deductible, copayment, or premium
19 results from increased costs caused by the use of a non-network provider. The
20 managed care entity shall provide an actuarial demonstration of the increased costs to
21 the director at the director's request. If the increased costs are not justified, the
22 director shall determine the appropriate costs allowed and determine the appropriate
23 amount of higher deductible, copayment, or premium. This subsection does not apply
24 to an enrollee who is offered non-network coverage through another group health plan
25 or through another managed care entity in the group market.
26 (b) The amount of any additional premium charged by the managed care entity
27 for the additional cost of the creation and maintenance of the option described in (a)
28 of this section and the amount of any additional cost sharing imposed under this option
29 shall be paid by the enrollee unless it is paid by the employer through agreement with
30 the managed care entity.
31 (c) An enrollee may make a change to the health care coverage option

1 provided under this section only during a time period determined by the managed care
2 entity. The time period described in this subsection must occur at least annually.
3 (d) If a managed care entity that offers a group managed care plan requires or
4 provides for a designation by an enrollee of a participating primary care provider, the
5 managed care entity shall permit the enrollee to designate any participating primary
6 care provider that is available to accept the enrollee.
7 (e) Except as provided in this subsection, a managed care entity that offers a
8 group managed care plan shall permit an enrollee to receive medically necessary or
9 appropriate specialty care, subject to appropriate referral procedures, from any qualified
10 participating health care provider that is available to accept the individual for medical
11 care. This subsection does not apply to specialty care if the managed care entity
12 clearly informs enrollees of the limitations on choice of participating health care
13 providers with respect to medical care. In this subsection,
14 (1) "appropriate referral procedures" means procedures for referring
15 patients to other health care providers as set out in the applicable member contract and
16 as described under (a) of this section;
17 (2) "specialty care" means care provided by a health care provider with
18 training and experience in treating a particular injury, illness, or condition.
19 (f) If a contract between a health care provider and a managed care entity is
20 terminated, a covered person may continue to be treated by that health care provider
21 as provided in this subsection. If a covered person is pregnant or being actively
22 treated by a provider on the date of the termination of the contract between that
23 provider and the managed care entity, the covered person may continue to receive
24 health care services from that provider as provided in this subsection, and the contract
25 between the managed care entity and the provider shall remain in force with respect
26 to the continuing treatment. The covered person shall be treated for the purposes of
27 benefit determination or claim payment as if the provider were still under contract with
28 the managed care entity. However, treatment is required to continue only while the
29 group managed care plan remains in effect and
30 (1) for the period that is the longest of the following:
31 (A) the end of the current plan year;

1 (B) up to 90 days after the termination date, if the event
2 triggering the right to continuing treatment is part of an ongoing course of
3 treatment; or
4 (C) through completion of postpartum care, if the covered
5 person is in the second trimester of pregnancy on the date of termination; or
6 (2) until the end of the medically necessary treatment for the condition,
7 disease, illness, or injury if the person has a terminal condition, disease, illness, or
8 injury; in this paragraph, "terminal" means a life expectancy of less than one year.
9 (g) The requirements of this section do not apply to health care services
10 covered by Medicaid.
11 **Sec. 21.07.040. Confidentiality of managed care information.** (a) Medical
12 and financial information in the possession of a managed care entity regarding an
13 applicant or a current or former person covered by a managed care plan is confidential
14 and is not subject to public disclosure.
15 (b) This section does not apply to medical information that is disclosed if
16 (1) the individual whose identity is disclosed gives written consent to
17 the disclosure;
18 (2) the information is disclosed for research
19 (A) that is subject to federal law and regulations protecting the
20 rights and welfare of research participants; or
21 (B) using health information that protects the confidentiality of
22 participants by coding or encryption of information that would otherwise
23 identify the patient;
24 (3) the information is disclosed for purposes of obtaining
25 reimbursement under health insurance;
26 (4) the information is disclosed at the written request of the covered
27 person;
28 (5) the disclosure is required by law.
29 **Sec. 21.07.050. External health care appeals.** (a) A managed care entity
30 offering group health insurance coverage shall provide for an external appeal process
31 that meets the requirements of this section in the case of an externally appealable

1 decision for which a timely appeal is made in writing either by the managed care
2 entity or by the enrollee.
3 (b) A managed care entity may condition the use of an external appeal process
4 in the case of an externally appealable decision upon a final decision in an internal
5 appeal under AS 21.07.020, but only if the decision is made in a timely basis
6 consistent with the deadlines provided under this chapter.
7 (c) Except as provided in this subsection, the external appeal process shall be
8 conducted under a contract between the managed care entity and one or more external
9 appeal agencies that have qualified under AS 21.07.060. The managed care entity
10 shall provide
11 (1) that the selection process among external appeal agencies qualifying
12 under AS 21.07.060 does not create any incentives for external appeal agencies to
13 make a decision in a biased manner;
14 (2) for auditing a sample of decisions by external appeal agencies to
15 assure that decisions are not made in a biased manner; and
16 (3) that all costs of the process, except those incurred by the enrollee
17 or treating professional in support of the appeal, shall be paid by the managed care
18 entity and not by the enrollee.
19 (d) An external appeal process must include at least the following:
20 (1) a fair, de novo determination based on coverage provided by the
21 plan and by applying terms as defined by the plan; however, nothing in this paragraph
22 may be construed as providing for coverage of items and services for which benefits
23 are excluded under the plan or coverage;
24 (2) an external appeal agency shall determine whether the managed care
25 entity's decision is (A) in accordance with the medical needs of the patient involved,
26 as determined by the managed care entity, taking into account, as of the time of the
27 managed care entity's decision, the patient's medical needs and any relevant and
28 reliable evidence the agency obtains under (3) of this subsection, and (B) in
29 accordance with the scope of the covered benefits under the plan; if the agency
30 determines the decision complies with this paragraph, the agency shall affirm the
31 decision, and, to the extent that the agency determines the decision is not in

1 accordance with this paragraph, the agency shall reverse or modify the decision;
2 (3) the external appeal agency shall include among the evidence taken
3 into consideration
4 (A) the decision made by the managed care entity upon internal
5 appeal under AS 21.07.020 and any guidelines or standards used by the
6 managed care entity in reaching a decision;
7 (B) any personal health and medical information supplied with
8 respect to the individual whose denial of claim for benefits has been appealed;
9 (C) the opinion of the individual's treating physician or health
10 care provider; and
11 (D) the group managed care plan;
12 (4) the external appeal agency may also take into consideration the
13 following evidence:
14 (A) the results of studies that meet professionally recognized
15 standards of validity and replicability or that have been published in peer-
16 reviewed journals;
17 (B) the results of professional consensus conferences conducted
18 or financed in whole or in part by one or more government agencies;
19 (C) practice and treatment guidelines prepared or financed in
20 whole or in part by government agencies;
21 (D) government-issued coverage and treatment policies;
22 (E) generally accepted principles of professional medical
23 practice;
24 (F) to the extent that the agency determines it to be free of any
25 conflict of interest, the opinions of individuals who are qualified as experts in
26 one or more fields of health care that are directly related to the matters under
27 appeal;
28 (G) to the extent that the agency determines it to be free of any
29 conflict of interest, the results of peer reviews conducted by the managed care
30 entity involved;
31 (H) the community standard of care; and

1 (I) anomalous utilization patterns;
2 (5) an external appeal agency shall determine
3 (A) whether a denial of a claim for benefits is an externally
4 appealable decision;
5 (B) whether an externally appealable decision involves an
6 expedited appeal; and
7 (C) for purposes of initiating an external review, whether the
8 internal appeal process has been completed;
9 (6) a party to an externally appealable decision may submit evidence
10 related to the issues in dispute;
11 (7) the managed care entity involved shall provide the external appeal
12 agency with access to information and to provisions of the plan or health insurance
13 coverage relating to the matter of the externally appealable decision, as determined by
14 the external appeal agency; and
15 (8) a determination by the external appeal agency on the decision must
16 (A) be made orally or in writing and, if it is made orally, shall
17 be supplied to the parties in writing as soon as possible;
18 (B) be made in accordance with the medical exigencies of the
19 case involved, but in no event later than 21 working days after the appeal is
20 filed, or, in the case of an expedited appeal, 72 hours after the time of
21 requesting an external appeal of the managed care entity's decision;
22 (C) state, in layperson's language, the basis for the
23 determination, including, if relevant, any basis in the terms or conditions of the
24 plan or coverage; and
25 (D) inform the enrollee of the individual's rights, including any
26 time limits, to seek further review by the courts of the external appeal
27 determination.
28 (e) If the external appeal agency reverses or modifies the denial of a claim for
29 benefits, the managed care entity shall
30 (1) upon receipt of the determination, authorize benefits in accordance
31 with that determination;

(2) take action as may be necessary to provide benefits, including items or services, in a timely manner consistent with the determination; and

(3) submit information to the external appeal agency documenting compliance with the agency's determination.

(f) A decision of an external appeal agency is binding unless a person who is aggrieved by a final decision of an external appeal agency appeals the decision to the superior court.

(g) An appeal of a final decision of an external appeal agency must be filed within six months after the date of the decision of the external appeal agency.

(h) In this section, "externally appealable decision"

(1) means

(A) a denial of a claim for benefits that is based in whole or in part on a decision that the item or service is not medically necessary or appropriate or is investigational or experimental, or in which the decision as to whether a benefit is covered involves a medical judgment; or

(B) a denial that is based on a failure to meet an applicable deadline for internal appeal under AS 21.07.020;

(2) does not include a decision based on specific exclusions or express limitations on the amount, duration, or scope of coverage that do not involve medical judgment, or a decision regarding whether an individual is a participant, beneficiary, or enrollee under the plan or coverage.

Sec. 21.07.060. Qualifications of external appeal agencies. (a) An external appeal agency qualifies to consider external appeals if, with respect to a group health plan, the agency is certified by a qualified private standard-setting organization approved by the director or by a health insurer operating in this state as meeting the requirements imposed under (b) of this section.

(b) An external appeal agency is qualified to consider appeals of group health plan health care decisions if the agency meets the following requirements:

(1) the agency meets the independence requirements of this section;

(2) the agency conducts external appeal activities through a panel of two clinical peers, unless otherwise agreed to by both parties; and

1 (3) the agency has sufficient medical, legal, and other expertise and
2 sufficient staffing to conduct external appeal activities for the managed care entity on
3 a timely basis consistent with this chapter.
4 (c) A clinical peer or other entity meets the independence requirements of this
5 section if
6 (1) the peer or entity does not have a familial, financial, or professional
7 relationship with a related party;
8 (2) compensation received by a peer or entity in connection with the
9 external review is reasonable and not contingent on any decision rendered by the peer
10 or entity;
11 (3) the plan and the issuer have no recourse against the peer or entity
12 in connection with the external review; and
13 (4) the peer or entity does not otherwise have a conflict of interest with
14 a related party.
15 (d) In this section, "related party" means
16 (1) with respect to
17 (A) a group health plan or health insurance coverage offered in
18 connection with a plan, the plan or the insurer offering the coverage; or
19 (B) individual health insurance coverage, the insurer offering
20 the coverage, or any plan sponsor, fiduciary, officer, director, or management
21 employee of the plan or issuer;
22 (2) the health care professional that provided the health care involved
23 in the coverage decision;
24 (3) the institution at which the health care involved in the coverage
25 decision is provided;
26 (4) the manufacturer of any drug or other item that was included in the
27 health care involved in the coverage decision;
28 (5) the covered person; or
29 (6) any other party that, under the regulations that the director may
30 prescribe, is determined by the director to have a substantial interest in the coverage
31 decision.

1 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal
2 agency qualifying under AS 21.07.060 and having a contract with a managed care
3 entity, and a person who is employed by the agency or who furnishes professional
4 services to the agency, may not be held by reason of the performance of any duty,
5 function, or activity required or authorized under this chapter to have violated any
6 criminal law, or to be civilly liable if due care was exercised in the performance of the
7 duty, function or activity and there was no actual malice or gross misconduct in the
8 performance of the duty, function, or activity.
9 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be
10 construed to
11 (1) restrict or limit the right of a managed care entity to include health
12 care services provided by a religious nonmedical provider as health care services
13 covered by the managed care plan;
14 (2) require a managed care entity, when determining coverage for
15 health care services provided by a religious nonmedical provider, to
16 (A) apply medically based eligibility standards;
17 (B) use health care providers to determine access by a covered
18 person;
19 (C) use health care providers in making a decision on an
20 internal or external appeal; or
21 (D) require a covered person to be examined by a health care
22 provider as a condition of coverage; or
23 (3) require a managed care plan to exclude coverage for health care
24 services provided by a religious nonmedical provider because the religious nonmedical
25 provider is not providing medical or other data required from a health care provider
26 if the medical or other data is inconsistent with the religious nonmedical treatment or
27 nursing care being provided.
28 **Sec. 21.07.250. Definitions.** In this chapter,
29 (1) "clinical peer" means a health care provider who is licensed to
30 provide the same or similar health care services and who is trained in the specialty or
31 subspecialty applicable to the health care services that are provided;

1 (2) "clinical trial" means treatment, research, study, or investigation
2 over a period of time of an injury, illness, or medical condition;
3 (3) "emergency room services" means health care services provided by
4 a hospital or other emergency facility after the sudden onset of a medical condition
5 that manifests itself by symptoms of sufficient severity, including severe pain, that the
6 absence of immediate medical attention would reasonably be expected by a prudent
7 person who possesses an average knowledge of health and medicine to result in
8 (A) the placing of the person's health in serious jeopardy;
9 (B) a serious impairment to bodily functions; or
10 (C) a serious dysfunction of a bodily organ or part;
11 (4) "group managed care plan" or "plan" means a group health
12 insurance plan operated by a managed care entity;
13 (5) "health care provider" means a person licensed in this state or
14 another state of the United States to provide health care services;
15 (6) "health care services" means treatment of an individual for an
16 injury, illness, or disability and includes preventative treatment of an injury or illness;
17 (7) "health insurance" has the meaning given in AS 21.12.050(a);
18 (8) "managed care" means a contract given to an individual, family, or
19 group of individuals under which a member is entitled to receive a defined set of
20 health care benefits in exchange for defined consideration and that requires the member
21 to comply with utilization review guide lines; "managed care" does not include
22 Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);
23 (9) "managed care contractor" means a contractor who establishes,
24 operates, or maintains a network of participating health care providers, conducts or
25 arranges for utilization review activities, and contracts with a managed care entity;
26 (10) "managed care entity" means an insurer, a hospital or medical
27 service corporation, a health maintenance organization, an employer or employee
28 health care organization, a managed care contractor that operates a group managed care
29 plan, or a person who has a financial interest in health care services provided to an
30 individual;
31 (11) "medical emergency" means the sudden onset of a medical

1 condition that manifests itself by symptoms of sufficient severity, including severe pain
2 that in the absence of immediate medical attention would reasonably be expected by
3 a prudent person who possesses an average knowledge of health and medicine to result
4 in

5 (A) the placing of the person's health in serious jeopardy;
6 (B) a serious impairment to bodily functions; or
7 (C) a serious dysfunction of any bodily organ or part;

8 (12) "participating health care provider" means a health care provider
9 who has entered into an agreement with a managed care entity to provide services or
10 supplies to a patient covered by a group managed care plan;

11 (13) "primary care provider" means a health care provider who provides
12 general health care services and does not specialize in treating a single injury, illness,
13 or condition or who provides obstetrical, gynecological, or pediatric health care
14 services;

15 (14) "provider" means a health care provider;

16 (15) "religious nonmedical provider" means a person who does not
17 provide medical care, but who provides only religious nonmedical treatment or nursing
18 care for an illness or injury;

19 (16) "utilization review" means a system of reviewing the medical
20 necessity, appropriateness, or quality of health care services and supplies provided
21 under a group managed care plan using specified guidelines, including preadmission
22 certification, the application of practice guidelines, continued stay review, discharge
23 planning, preauthorization of ambulatory procedures, and retrospective review;

24 (17) "working day" means a day of the week that is not a Saturday,
25 Sunday, or a holiday.

26 * **Sec. 3.** AS 21.36.125 is amended by adding a new paragraph to read:

27 (16) violate a provision contained in AS 21.07.

28 * **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section
29 to read:

30 INDIRECT COURT RULE AMENDMENT. AS 21.07.050(g), as enacted by sec. 2
31 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by

1 providing that an appeal from a decision of an external appeal agency must be filed within
2 six months of the decision of the external appeal agency.
3 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section
4 to read:
5 CONDITIONAL EFFECT. AS 21.07.050(g), as enacted by sec. 2 of this Act, takes
6 effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required
7 by art. IV, sec. 15, Constitution of the State of Alaska.
8 * **Sec. 6.** This Act takes effect July 1, 2001.

4/10/00
JUD

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

M E M O R A N D U M

April 7, 2000

SUBJECT: Managed care - (CSHB 211(JUD))

TO: Representative Pete Kott
Attn: Lesil

FROM: Michael F. Ford *M.F.*
Legislative Counsel

The draft you requested is attached. I have added the new provision regarding "medical necessity" as a new paragraph 2 in Sec. 21.07.020, beginning on page 3, line 25. This provision raises issues regarding other existing provisions in the bill, however. I believe it is necessary to also change Sec. 21.07.020(1), (5)(B) and (6)(B). These are provisions that also involve determinations regarding "medical necessity" and need to be amended to avoid conflicts or duplications. You could simply remove the conflicting provisions, but this may be a change that is too drastic. In short there is no quick fix for this situation. One approach you may consider is to make Sec. 21.07.020(1) contingent on compliance with Sec. 21.07.020(2), and simply remove Sec. 21.07.020(5)(B) and (6)(B), but that still leaves the issue of "utilization review". Utilization review, as defined in Sec. 21.07.250, includes a determination of "medical necessity". You could specifically exclude "medical necessity" from the utilization review process and leave this issue to the independent review organization. Again this may require other adjustments to the bill.

Let me know what you decide.

MFF:glc
00-165.glc

4/10/00 JUD

1-LS0472\V
Ford
4/7/00

adopted 4/10 amended + moved out

CS FOR HOUSE BILL NO. 211(JUD)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY THE HOUSE JUDICIARY COMMITTEE

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulation of managed care insurance plans; amending Rule**
2 **602(b), Alaska Rules of Appellate Procedure; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** The uncodified law of the State of Alaska is amended by adding a new
5 section to read:
6 SHORT TITLE. Section 2 of this Act may be known as the Alaska Patients' Bill of
7 Rights.
8 * **Sec. 2.** AS 21 is amended by adding a new chapter to read:
9 **Chapter 07. Regulation of Managed Care Insurance Plans.**
10 **Sec. 21.07.010. Patient and health care provider protection.** (a) A contract
11 between a participating health care provider and a managed care entity that offers a
12 group managed care plan must contain a provision that
13 (1) provides for a reasonable mechanism to identify all health care
14 services to be provided by the managed care entity;

New Text Underlined [DELETED TEXT BRACKETED]

1 (2) clearly states or references an attachment that states the health care
2 provider's rate of compensation;
3 (3) clearly states all ways in which the contract between the health care
4 provider and managed care entity may be terminated; a provision that provides for
5 discretionary termination by either party must apply equitably to both parties;
6 (4) provides that, in the event of a dispute between the parties to the
7 contract, a fair, prompt, and mutual dispute resolution process must be used; at a
8 minimum, the process must provide
9 (A) for an initial meeting at which all parties are present or
10 represented by individuals with authority regarding the matters in dispute; the
11 meeting shall be held within 10 working days after the plan receives written
12 notice of the dispute or gives written notice to the provider, unless the parties
13 otherwise agree in writing to a different schedule;
14 (B) that if, within 30 days following the initial meeting, the
15 parties have not resolved the dispute, the dispute shall be submitted to
16 mediation directed by a mediator who is mutually agreeable to the parties and
17 who is not regularly under contract to or employed by either of the parties;
18 each party shall bear its proportionate share of the cost of mediation, including
19 the mediator fees;
20 (C) that if, after a period of 60 days following commencement
21 of mediation, the parties are unable to resolve the dispute, either party may
22 seek other relief allowed by law;
23 (D) that the parties shall agree to negotiate in good faith in the
24 initial meeting and in mediation;
25 (5) states that a health care provider may not be penalized or the health
26 care provider's contract terminated by the managed care entity because the health care
27 provider acts as an advocate for a covered person in seeking appropriate, medically
28 necessary health care services;
29 (6) protects the ability of a health care provider to communicate openly
30 with a covered person about all appropriate diagnostic testing and treatment options;
31 and

1 (7) defines words in a clear and concise manner.
2 (b) A contract between a participating health care provider and a managed care
3 entity that offers a group managed care plan may not contain a provision that
4 (1) has as its predominant purpose the creation of direct financial
5 incentives to the health care provider for withholding covered health care services that
6 are medically necessary; nothing in this paragraph shall be construed to prohibit a
7 contract between a participating health care provider and a managed care entity from
8 containing incentives for efficient management of the utilization and cost of covered
9 health care services;
10 (2) requires the provider to contract for all products that are currently
11 offered or that may be offered in the future by the managed care entity; and
12 (3) requires the health care provider to be compensated for health care
13 services performed at the same rate as the health care provider has contracted with
14 another managed care entity.
15 (c) A managed care entity may not enter into a contract with a health care
16 provider that requires the provider to indemnify or hold harmless the managed care
17 entity for the acts [or misconduct] of the managed care entity. An indemnification or hold harmless
18 clause entered into in violation of this subsection is void.
19 **Sec. 21.07.020. Required contract provisions for group managed care**
20 **plans.** A group managed care plan must contain
21 (1) a provision that preauthorization for a covered medical procedure
22 on the basis of medical necessity may not be retroactively denied unless the
23 preauthorization is based on materially incomplete or inaccurate information provided
24 by or on behalf of the provider;
25 (2) a provision that a determination regarding the medical necessity or
26 appropriateness of health care services for an enrollee or the application of managed
27 care plan provisions to an enrollee must be made by medical reviewers from an
28 independent review organization; a determination by a medical reviewer shall be based
29 on the medical reviewer's expert medical judgment, after consideration of relevant
30 medical, scientific, and cost-effective evidence, and medical standards of practice in
31 this state; except as provided in this paragraph, the independent review organization

1 must ensure that a determination is consistent with the scope of covered benefits as
2 outlined in the managed care plan; a medical reviewer may override the managed care
3 plan's standard of medical necessity or appropriateness of health care services if the
4 standard is determined by the medical reviewer to be unreasonable or inconsistent with
5 sound, evidence-based medical practice;
6 (3) a provision for emergency room services if any coverage is
7 provided for treatment of a medical emergency;
8 (4) a provision that covered health care services be reasonably available
9 in the community in which a covered person resides or that, if referrals are required
10 by the plan, adequate referrals outside the community be available if the health care
11 service is not available in the community;
12 (5) a provision that any utilization review decision
13 (A) must be made within 72 hours after receiving the request
14 for preapproval for nonemergency situations; for emergency situations,
15 utilization review decisions for care following emergency services must be
16 made as soon as is practicable but in any event no later than 24 hours after
17 receiving the request for preapproval or for coverage determination; and
18 (B) to deny, reduce, or terminate a health care benefit or to
19 deny payment for a health care service because that service is not medically
20 necessary shall be made by an employee or agent of the managed care entity
21 who is a licensed health care provider;
22 (6) a provision that provides for an internal appeal mechanism for a
23 covered person who disagrees with a utilization review decision made by a managed
24 care entity; except as provided under (7) of this section, this appeal mechanism must
25 provide for a written decision
26 (A) from the managed care entity within 18 working days after
27 the date written notice of an appeal is received; and
28 (B) on the appeal by an employee or agent of the managed care
29 entity who holds the same professional license as the health care provider who
30 is treating the covered person;
31 (7) a provision that provides for an internal appeal mechanism for a

1 covered person who disagrees with a utilization review decision made by a managed
2 care entity in any case in which delay would, in the written opinion of the treating
3 provider, jeopardize the covered person's life or materially jeopardize the covered
4 person's health; the managed care entity shall
5 (A) decide an appeal described in this paragraph within 72
6 hours after receiving the appeal; and
7 (B) provide for a written decision on the appeal by an employee
8 or agent of the managed care entity who holds the same professional license
9 as the health care provider who is treating the covered person;
10 (8) a provision that discloses the existence of the right to an external
11 appeal of a utilization review decision made by a managed care entity; the external
12 appeal shall be as conducted in accordance with AS 21.07.050;
13 (9) a provision that discloses covered benefits, optional supplemental
14 benefits, and benefits relating to and restrictions on nonparticipating provider services;
15 (10) a provision that describes the preapproval requirements and
16 whether clinical trials or experimental or investigational treatment are covered;
17 (11) a provision describing a mechanism for assignment of benefits for
18 health care providers and payment of benefits;
19 (12) a provision describing availability of prescription medications or
20 a formulary guide, and whether medications not listed are excluded; if a formulary
21 guide is made available, the guide must be updated annually; and
22 (13) a provision describing available translation or interpreter services,
23 including audiotape or braille information.
24 **Sec. 21.07.030. Choice of health care provider.** (a) If a managed care entity
25 offers a group health plan that provides for coverage of health care services only if the
26 services are furnished through a network of health care providers that have entered into
27 a contract with the managed care entity, the managed care entity shall also offer a non-
28 network option to enrollees at initial enrollment, as provided under (c) of this section.
29 The non-network option may require that a covered person pay a higher deductible,
30 copayment, or premium for the plan if the higher deductible, copayment, or premium
31 results from increased costs caused by the use of a non-network provider. The

1 managed care entity shall provide an actuarial demonstration of the increased costs to
2 the director at the director's request. If the increased costs are not justified, the
3 director shall determine the appropriate costs allowed and determine the appropriate
4 amount of higher deductible, copayment, or premium. This subsection does not apply
5 to an enrollee who is offered non-network coverage through another group health plan
6 or through another managed care entity in the group market.
7 (b) The amount of any additional premium charged by the managed care entity
8 for the additional cost of the creation and maintenance of the option described in (a)
9 of this section and the amount of any additional cost sharing imposed under this option
10 shall be paid by the enrollee unless it is paid by the employer through agreement with
11 the managed care entity.
12 (c) An enrollee may make a change to the health care coverage option
13 provided under this section only during a time period determined by the managed care
14 entity. The time period described in this subsection must occur at least annually.
15 (d) If a managed care entity that offers a group managed care plan requires or
16 provides for a designation by an enrollee of a participating primary care provider, the
17 managed care entity shall permit the enrollee to designate any participating primary
18 care provider that is available to accept the enrollee.
19 (e) Except as provided in this subsection, a managed care entity that offers a
20 group managed care plan shall permit an enrollee to receive medically necessary or
21 appropriate specialty care, subject to appropriate referral procedures, from any qualified
22 participating health care provider that is available to accept the individual for medical
23 care. This subsection does not apply to specialty care if the managed care entity
24 clearly informs enrollees of the limitations on choice of participating health care
25 providers with respect to medical care. In this subsection,
26 (1) "appropriate referral procedures" means procedures for referring
27 patients to other health care providers as set out in the applicable member contract and
28 as described under (a) of this section;
29 (2) "specialty care" means care provided by a health care provider with
30 training and experience in treating a particular injury, illness, or condition.
31 (f) If a contract between a health care provider and a managed care entity is

1 terminated, a covered person may continue to be treated by that health care provider
2 as provided in this subsection. If a covered person is pregnant or being actively
3 treated by a provider on the date of the termination of the contract between that
4 provider and the managed care entity, the covered person may continue to receive
5 health care services from that provider as provided in this subsection, and the contract
6 between the managed care entity and the provider shall remain in force with respect
7 to the continuing treatment. The covered person shall be treated for the purposes of
8 benefit determination or claim payment as if the provider were still under contract with
9 the managed care entity. However, treatment is required to continue only while the
10 group managed care plan remains in effect and
11 (1) for the period that is the longest of the following:
12 (A) the end of the current plan year;
13 (B) up to 90 days after the termination date, if the event
14 triggering the right to continuing treatment is part of an ongoing course of
15 treatment; or
16 (C) through completion of postpartum care, if the covered
17 person is in the second trimester of pregnancy on the date of termination; or
18 (2) until the end of the medically necessary treatment for the condition,
19 disease, illness, or injury if the person has a terminal condition, disease, illness, or
20 injury; in this paragraph, "terminal" means a life expectancy of less than one year.
21 (g) The requirements of this section do not apply to health care services
22 covered by Medicaid.
23 **Sec. 21.07.040. Confidentiality of managed care information.** (a) Medical
24 and financial information in the possession of a managed care entity regarding an
25 applicant or a current or former person covered by a managed care plan is confidential
26 and is not subject to public disclosure.
27 (b) This section does not apply to medical information that is disclosed if
28 (1) the individual whose identity is disclosed gives written consent to
29 the disclosure;
30 (2) the information is disclosed for research
31 (A) that is subject to federal law and regulations protecting the

1 rights and welfare of research participants; or
2 (B) using health information that protects the confidentiality of
3 participants by coding or encryption of information that would otherwise
4 identify the patient;
5 (3) the information is disclosed for purposes of obtaining
6 reimbursement under health insurance;
7 (4) the information is disclosed at the written request of the covered
8 person;
9 (5) the disclosure is required by law.
10 **Sec. 21.07.050. External health care appeals.** (a) A managed care entity
11 offering group health insurance coverage shall provide for an external appeal process
12 that meets the requirements of this section in the case of an externally appealable
13 decision for which a timely appeal is made in writing either by the managed care
14 entity or by the enrollee.
15 (b) A managed care entity may condition the use of an external appeal process
16 in the case of an externally appealable decision upon a final decision in an internal
17 appeal under AS 21.07.020, but only if the decision is made in a timely basis
18 consistent with the deadlines provided under this chapter.
19 (c) Except as provided in this subsection, the external appeal process shall be
20 conducted under a contract between the managed care entity and one or more external
21 appeal agencies that have qualified under AS 21.07.060. The managed care entity
22 shall provide
23 (1) that the selection process among external appeal agencies qualifying
24 under AS 21.07.060 does not create any incentives for external appeal agencies to
25 make a decision in a biased manner;
26 (2) for auditing a sample of decisions by external appeal agencies to
27 assure that decisions are not made in a biased manner; and
28 (3) that all costs of the process, except those incurred by the enrollee
29 or treating professional in support of the appeal, shall be paid by the managed care
30 entity and not by the enrollee.
31 (d) An external appeal process must include at least the following:

1 (1) a fair, de novo determination based on coverage provided by the
2 plan and by applying terms as defined by the plan; however, nothing in this paragraph
3 may be construed as providing for coverage of items and services for which benefits
4 are excluded under the plan or coverage;
5 (2) an external appeal agency shall determine whether the managed care
6 entity's decision is (A) in accordance with the medical needs of the patient involved,
7 as determined by the managed care entity, taking into account, as of the time of the
8 managed care entity's decision, the patient's medical needs and any relevant and
9 reliable evidence the agency obtains under (3) of this subsection, and (B) in
10 accordance with the scope of the covered benefits under the plan; if the agency
11 determines the decision complies with this paragraph, the agency shall affirm the
12 decision, and, to the extent that the agency determines the decision is not in
13 accordance with this paragraph, the agency shall reverse or modify the decision;
14 (3) the external appeal agency shall include among the evidence taken
15 into consideration
16 (A) the decision made by the managed care entity upon internal
17 appeal under AS 21.07.020 and any guidelines or standards used by the
18 managed care entity in reaching a decision;
19 (B) any personal health and medical information supplied with
20 respect to the individual whose denial of claim for benefits has been appealed;
21 (C) the opinion of the individual's treating physician or health
22 care provider; and
23 (D) the group managed care plan;
24 (4) the external appeal agency may also take into consideration the
25 following evidence:
26 (A) the results of studies that meet professionally recognized
27 standards of validity and replicability or that have been published in peer-
28 reviewed journals;
29 (B) the results of professional consensus conferences conducted
30 or financed in whole or in part by one or more government agencies;
31 (C) practice and treatment guidelines prepared or financed in

1 whole or in part by government agencies;
2 (D) government-issued coverage and treatment policies;
3 (E) generally accepted principles of professional medical
4 practice;
5 (F) to the extent that the agency determines it to be free of any
6 conflict of interest, the opinions of individuals who are qualified as experts in
7 one or more fields of health care that are directly related to the matters under
8 appeal;
9 (G) to the extent that the agency determines it to be free of any
10 conflict of interest, the results of peer reviews conducted by the managed care
11 entity involved;
12 (H) the community standard of care; and
13 (I) anomalous utilization patterns;
14 (5) an external appeal agency shall determine
15 (A) whether a denial of a claim for benefits is an externally
16 appealable decision;
17 (B) whether an externally appealable decision involves an
18 expedited appeal; and
19 (C) for purposes of initiating an external review, whether the
20 internal appeal process has been completed;
21 (6) a party to an externally appealable decision may submit evidence
22 related to the issues in dispute;
23 (7) the managed care entity involved shall provide the external appeal
24 agency with access to information and to provisions of the plan or health insurance
25 coverage relating to the matter of the externally appealable decision, as determined by
26 the external appeal agency; and
27 (8) a determination by the external appeal agency on the decision must
28 (A) be made orally or in writing and, if it is made orally, shall
29 be supplied to the parties in writing as soon as possible;
30 (B) be made in accordance with the medical exigencies of the
31 case involved, but in no event later than 21 working days after the appeal is

1 filed, or, in the case of an expedited appeal, 72 hours after the time of
2 requesting an external appeal of the managed care entity's decision;
3 (C) state, in layperson's language, the basis for the
4 determination, including, if relevant, any basis in the terms or conditions of the
5 plan or coverage; and
6 (D) inform the enrollee of the individual's rights, including any
7 time limits, to seek further review by the courts of the external appeal
8 determination.
9 (e) If the external appeal agency reverses or modifies the denial of a claim for
10 benefits, the managed care entity shall
11 (1) upon receipt of the determination, authorize benefits in accordance
12 with that determination;
13 (2) take action as may be necessary to provide benefits, including items
14 or services, in a timely manner consistent with the determination; and
15 (3) submit information to the external appeal agency documenting
16 compliance with the agency's determination.
17 (f) A decision of an external appeal agency is binding unless a person who is
18 aggrieved by a final decision of an external appeal agency appeals the decision to the
19 superior court.
20 (g) An appeal of a final decision of an external appeal agency must be filed
21 within six months after the date of the decision of the external appeal agency.
22 (h) In this section, "externally appealable decision"
23 (1) means
24 (A) a denial of a claim for benefits that is based in whole or in
25 part on a decision that the item or service is not medically necessary or
26 appropriate or is investigational or experimental, or in which the decision as to
27 whether a benefit is covered involves a medical judgment; or
28 (B) a denial that is based on a failure to meet an applicable
29 deadline for internal appeal under AS 21.07.020;
30 (2) does not include a decision based on specific exclusions or express
31 limitations on the amount, duration, or scope of coverage that do not involve medical

1 judgment, or a decision regarding whether an individual is a participant, beneficiary,
2 or enrollee under the plan or coverage.
3 **Sec. 21.07.060. Qualifications of external appeal agencies.** (a) An external
4 appeal agency qualifies to consider external appeals if, with respect to a group health
5 plan, the agency is certified by a qualified private standard-setting organization
6 approved by the director or by a health insurer operating in this state as meeting the
7 requirements imposed under (b) of this section.
8 (b) An external appeal agency is qualified to consider appeals of group health
9 plan health care decisions if the agency meets the following requirements:
10 (1) the agency meets the independence requirements of this section;
11 (2) the agency conducts external appeal activities through a panel of
12 two clinical peers, unless otherwise agreed to by both parties; and
13 (3) the agency has sufficient medical, legal, and other expertise and
14 sufficient staffing to conduct external appeal activities for the managed care entity on
15 a timely basis consistent with this chapter.
16 (c) A clinical peer or other entity meets the independence requirements of this
17 section if
18 (1) the peer or entity does not have a familial, financial, or professional
19 relationship with a related party;
20 (2) compensation received by a peer or entity in connection with the
21 external review is reasonable and not contingent on any decision rendered by the peer
22 or entity;
23 (3) the plan and the issuer have no recourse against the peer or entity
24 in connection with the external review; and
25 (4) the peer or entity does not otherwise have a conflict of interest with
26 a related party.
27 (d) In this section, "related party" means
28 (1) with respect to
29 (A) a group health plan or health insurance coverage offered in
30 connection with a plan, the plan or the insurer offering the coverage; or
31 (B) individual health insurance coverage, the insurer offering

1 the coverage, or any plan sponsor, fiduciary, officer, director, or management
2 employee of the plan or issuer;
3 (2) the health care professional that provided the health care involved
4 in the coverage decision;
5 (3) the institution at which the health care involved in the coverage
6 decision is provided;
7 (4) the manufacturer of any drug or other item that was included in the
8 health care involved in the coverage decision;
9 (5) the covered person; or
10 (6) any other party that, under the regulations that the director may
11 prescribe, is determined by the director to have a substantial interest in the coverage
12 decision.
13 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal
14 agency qualifying under AS 21.07.060 and having a contract with a managed care
15 entity, and a person who is employed by the agency or who furnishes professional
16 services to the agency, may not be held by reason of the performance of any duty,
17 function, or activity required or authorized under this chapter to have violated any
18 criminal law, or to be civilly liable if due care was exercised in the performance of the
19 duty, function or activity and there was no actual malice or gross misconduct in the
20 performance of the duty, function, or activity.
21 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be
22 construed to
23 (1) restrict or limit the right of a managed care entity to include health
24 care services provided by a religious nonmedical provider as health care services
25 covered by the managed care plan;
26 (2) require a managed care entity, when determining coverage for
27 health care services provided by a religious nonmedical provider, to
28 (A) apply medically based eligibility standards;
29 (B) use health care providers to determine access by a covered
30 person;
31 (C) use health care providers in making a decision on an

1 internal or external appeal; or
2 (D) require a covered person to be examined by a health care
3 provider as a condition of coverage; or
4 (3) require a managed care plan to exclude coverage for health care
5 services provided by a religious nonmedical provider because the religious nonmedical
6 provider is not providing medical or other data required from a health care provider
7 if the medical or other data is inconsistent with the religious nonmedical treatment or
8 nursing care being provided.
9 **Sec. 21.07.250. Definitions.** In this chapter,
10 (1) "clinical peer" means a health care provider who is licensed to
11 provide the same or similar health care services and who is trained in the specialty or
12 subspecialty applicable to the health care services that are provided;
13 (2) "clinical trial" means treatment, research, study, or investigation
14 over a period of time of an injury, illness, or medical condition;
15 (3) "emergency room services" means health care services provided by
16 a hospital or other emergency facility after the sudden onset of a medical condition
17 that manifests itself by symptoms of sufficient severity, including severe pain, that the
18 absence of immediate medical attention would reasonably be expected by a prudent
19 person who possesses an average knowledge of health and medicine to result in
20 (A) the placing of the person's health in serious jeopardy;
21 (B) a serious impairment to bodily functions; or
22 (C) a serious dysfunction of a bodily organ or part;
23 (4) "group managed care plan" or "plan" means a group health
24 insurance plan operated by a managed care entity;
25 (5) "health care provider" means a person licensed in this state or
26 another state of the United States to provide health care services;
27 (6) "health care services" means treatment of an individual for an
28 injury, illness, or disability and includes preventative treatment of an injury or illness;
29 (7) "health insurance" has the meaning given in AS 21.12.050(a);
30 (8) "managed care" means a contract given to an individual, family, or
31 group of individuals under which a member is entitled to receive a defined set of

1 health care benefits in exchange for defined consideration and that requires the member
2 to comply with utilization review guide lines; "managed care" does not include
3 Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);
4 (9) "managed care contractor" means a contractor who establishes,
5 operates, or maintains a network of participating health care providers, conducts or
6 arranges for utilization review activities, and contracts with a managed care entity;
7 (10) "managed care entity" means an insurer, a hospital or medical
8 service corporation, a health maintenance organization, an employer or employee
9 health care organization, a managed care contractor that operates a group managed care
10 plan, or a person who has a financial interest in health care services provided to an
11 individual;
12 (11) "medical emergency" means the sudden onset of a medical
13 condition that manifests itself by symptoms of sufficient severity, including severe pain
14 that in the absence of immediate medical attention would reasonably be expected by
15 a prudent person who possesses an average knowledge of health and medicine to result
16 in
17 (A) the placing of the person's health in serious jeopardy;
18 (B) a serious impairment to bodily functions; or
19 (C) a serious dysfunction of any bodily organ or part;
20 (12) "participating health care provider" means a health care provider
21 who has entered into an agreement with a managed care entity to provide services or
22 supplies to a patient covered by a group managed care plan;
23 (13) "primary care provider" means a health care provider who provides
24 general health care services and does not specialize in treating a single injury, illness,
25 or condition or who provides obstetrical, gynecological, or pediatric health care
26 services;
27 (14) "provider" means a health care provider;
28 (15) "religious nonmedical provider" means a person who does not
29 provide medical care, but who provides only religious nonmedical treatment or nursing
30 care for an illness or injury;
31 (16) "utilization review" means a system of reviewing the medical

1 necessity, appropriateness, or quality of health care services and supplies provided
2 under a group managed care plan using specified guidelines, including preadmission
3 certification, the application of practice guidelines, continued stay review, discharge
4 planning, preauthorization of ambulatory procedures, and retrospective review;
5 (17) "working day" means a day of the week that is not a Saturday,
6 Sunday, or a holiday.
7 * **Sec. 3.** AS 21.36.125 is amended by adding a new paragraph to read:
8 (16) violate a provision contained in AS 21.07.
9 * **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section
10 to read:
11 INDIRECT COURT RULE AMENDMENT. AS 21.07.050(g), as enacted by sec. 2
12 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by
13 providing that an appeal from a decision of an external appeal agency must be filed within
14 six months of the decision of the external appeal agency.
15 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section
16 to read:
17 CONDITIONAL EFFECT. AS 21.07.050(g), as enacted by sec. 2 of this Act, takes
18 effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required
19 by art. IV, sec. 15, Constitution of the State of Alaska.
20 * **Sec. 6.** This Act takes effect July 1, 2001.

Alaska State Medical Association

4107 Laurel Street · Anchorage, Alaska 99508 · (907)562-0304 · (907)561-2063 (fax)

FAX COVER SHEET

Pages (including cover sheet): 18

TO: Lisel McGuire 907-465-2819

FROM: Jim Jordan

DATE: April 3, 2000

MESSAGE:

/kms

Insert 1.

21.07.010 (a) (3) from K version p. 3, line 16 and 17 remove and insert as the new (3)

"(3) clearly identifies and describes each health benefit plan for ~~those~~ which ~~enrollees with~~ the manage care entity intends to have the participating health care provider ~~[illegible]~~ ~~[illegible]~~ provide services ~~to~~ to those enrolled in those health benefit plans;"

Insert 2

On page 4 of N, line 7 after the ";" add the following clause:

"however, if the treating health care provider is a physician than the employee or agent of the managed care entity shall be a licensed physician;"

WORK DRAFT WORK DRAFT WORK DRAFT

1-LS0472\N
Ford
3/30/00

CS FOR HOUSE BILL NO. 211( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulation of managed care insurance plans; amending Rule**
2 **602(b), Alaska Rules of Appellate Procedure; and providing for an effective date."**

Keep original title (version K)

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new
5 section to read:
6 SHORT TITLE. Section 2 of this Act may be known as the Alaska Patients' Bill of
7 Rights.
8 *** Sec. 2.** AS 21 is amended by adding a new chapter to read:
9 **Chapter 07. Regulation of Managed Care Insurance Plans.**
10 **Sec. 21.07.010. Patient and health care provider protection.** (a) A contract
11 between a participating health care provider and a managed care entity that offers a
12 group managed care plan must contain a provision that
13 (1) clearly states or references an attachment that states the health care
14 provider's rate of compensation;

Keep version (K) liability section Sec 09.65.175

Keep version K chapter 07 Sec 21.07.010 (1), (3), (4), (5), (6), (7), (8), (9)

New Text Underlined [DELETED TEXT BRACKETED]

See insert 1.

1 (2) clearly states all ways in which the contract between the health care
2 provider and managed care entity may be terminated; a provision that provides for
3 discretionary termination by either party must apply equitably to both parties;
4 (3) provides that, in the event of a dispute between the parties to the
5 contract, a fair, prompt, and mutual dispute resolution process must be used; at a
6 minimum, the process must provide
7 (A) for an initial meeting at which all parties are present or
8 represented by individuals with authority regarding the matters in dispute; the
9 meeting shall be held within 14 working days after the plan receives written
10 notice of the dispute or gives written notice to the provider, unless the parties
11 otherwise agree in writing to a different schedule;
12 (B) that if, within 30 days following the initial meeting, the
13 parties have not resolved the dispute, the dispute shall be submitted to
14 mediation directed by a mediator who is mutually agreeable to the parties and
15 who is not regularly under contract to or employed by either of the parties;
16 each party shall bear its proportionate share of the cost of mediation, including
17 the mediator fees;
18 (C) that if after a period of 60 days following commencement
19 of mediation, the parties are unable to resolve the dispute, either party may
20 seek other relief allowed by law;
21 (D) that the parties shall agree to negotiate in good faith in the
22 initial meeting and in med[illegible]ion;
23 (4) states that a health care provider may not be penalized or the health
24 care provider's contract terminated by the managed care entity because the health care
25 provider acts as an advocate for a covered person in seeking appropriate, medically
26 necessary health care services;
27 (5) protects the ability of a health care provider to communicate openly
28 with a covered person about all appropriate diagnostic testing and treatment options;
29 and
30 (6) defines words in a clear and concise manner.
31 (b) A contract between a participating health care provider and a managed care

need original version (C) Chapter (7) Sec 21.07.010 (1),(4),(5),(6),(7),(8),(9)

1 entity that offers a group managed care plan may not contain a provision that
2 (1) has as its predominant purpose the creation of direct financial
3 incentives to the health care provider for withholding covered health care services that
4 are medically necessary; nothing in this paragraph shall be construed to prohibit a
5 contract between a participating health care provider and a managed care entity from
6 containing incentives for efficient management of the utilization and cost of covered
7 health care services;
8 (2) requires the provider to purchase or use all products that are
9 currently offered or that may be offered in the future by the managed care entity; and
10 (3) requires the health care provider to be compensated for health care
11 services performed at the same rate as the health care provider has contracted with
12 another managed care entity.
13 (c) A managed care entity may not enter into a contract with a health care
14 provider that requires the provider to indemnify or hold harmless the managed care
15 entity. An indemnification or hold harmless clause entered into in violation of this
16 subsection is void.

Keep version (K) indemnification language pg 5 lines 11-14

17 **Sec. 21.07.020. Required contract provisions for group managed care**
18 **plans.** A group managed care plan must contain
19 (1) a provision that preauthorization for a covered medical procedure
20 on the basis of medical necessity may not be retroactively denied unless the
21 preauthorization is based on materially incomplete or inaccurate information provided
22 by or on behalf of the provider;

OK

23 (2) a provision for emergency room services if any coverage is
24 provided for treatment of a medical emergency;
25 (3) a provision that covered health care services be reasonably available
26 in the community in which a covered person resides or that adequate referrals outside
27 the community be available if the health care service is not available in the
28 community;

OK

29 (4) a provision that any utilization review decision
30 (A) must be made within 72 hours after receiving the request
31 for preapproval for nonemergency situations; for emergency situations,

OK

1 utilization review decisions for care following emergency services must be
2 made as soon as is practicable but in any event no later than 24 hours after
3 receiving the request for preapproval or for coverage determination; and
4 (B) to deny, reduce, or terminate a health care benefit or to
5 deny payment for a health care service because that service is not medically
6 necessary shall be made by an employee or agent of the managed care entity
7 who is a licensed health care provider; → See Insert 2.
8 (5) a provision that provides for an internal appeal mechanism for a
9 covered person who disagrees with a utilization review decision made by a managed
10 care entity; except as provided under (6) of this section, this appeal mechanism must
11 provide for a written decision from the managed care entity within ~~20~~ 15 working days
12 after the date written notice of an appeal is received;
13 (6) a provision that provides for an internal appeal mechanism for a
14 covered person who disagrees with a utilization review decision made by a managed
15 care entity in any case in which delay would, in the ~~written~~ opinion of the treating
16 provider, jeopardize the covered person's life or materially jeopardize the covered
17 person's health; the managed care entity shall decide an appeal described in this
18 paragraph within 72 hours after receiving the appeal;
19 (7) a provision that discloses the existence of the right to an external
20 appeal of a utilization review decision made by a managed care entity; the external
21 appeal shall be as conducted in accordance with AS 21.07.050;
22 (8) a provision that discloses covered benefits, optional supplemental
23 benefits, and benefits relating to and restrictions on nonparticipating provider services;
24 (9) a provision that describes covered service area, the preapproval requirements and whether
25 clinical trials or experimental or investigational treatment are covered;
26 (10) a provision describing compensation methodology, assignment of benefits for health care
27 providers and health care facilities;
28 (11) a provision describing availability of prescription medications or
29 a formulary guide ~~and its structure~~ including specific exclusions; if a formulary guide is made available, the guide
30 must be updated annually; and
31 (12) a provision describing available translation or interpreter services.

Handwritten margin notes: "version (C) language is better but highlighted language would do." / "OK with change" / "OK with change" / "OK" / "OK" / "OK with change" / "ok with change" / "ok with change" / "ok"

1 including audiotape or braille information.

2 Sec. 21.07.030. Choice of health care provider. (a) If a managed care entity
3 offers a group health plan that provides for coverage of health care services only if the
4 services are furnished through a network of health care providers that have entered into
5 a contract with the managed care entity, the managed care entity shall also offer a non-
6 network option to enrollees at initial enrollment, as provided under (c) of this section.
7 The non-network option may require that a covered person pay a higher deductible or
8 copayment and a higher premium for the plan. This subsection does not apply to an
9 enrollee who is offered non-network coverage through another group health plan or
10 through another managed care entity in the group market.

Keep UCBM (k) 21.07.030 (a)

11 (b) The amount of any additional premium charged by the managed care entity
12 for the additional cost of the creation and maintenance of the option described in (a)
13 of this section and the amount of any additional cost sharing imposed under this option
14 shall be paid by the enrollee unless it is paid by the employer through agreement with
15 the managed care entity.

ok

16 (c) An enrollee may make a change to the health care coverage option
17 provided under this section only during a time period determined by the managed care
18 entity. The time period described in this subsection must occur at least annually.

ok

19 (d) If a managed care entity that offers a group managed care plan requires or
20 provides for a designation by an enrollee of a participating primary care provider, the
21 managed care entity shall permit the enrollee to designate any participating primary
22 care provider that is available to accept the enrollee.

ok

23 (e) Except as provided in this subsection, a managed care entity that offers a
24 group managed care plan shall permit an enrollee to receive medically necessary or
25 appropriate specialty care, subject to appropriate referral procedures, from any qualified
26 participating health care provider that is available to accept the individual for medical
27 care. This subsection does not apply to specialty care if the managed care entity
28 clearly informs enrollees of the limitations on choice of participating health care
29 providers with respect to medical care. In this subsection,

ok

30 (1) "appropriate referral procedures" means procedures for referring
31 patients to other health care providers [redacted]

that comply with ethical guidelines established by the American Medical Association.

ok with change

1 [redacted]
2 (2) "specialty care" means care provided by a health care provider with
3 training and experience in treating a particular injury, illness, or condition.
4 (f) A managed care entity shall notify a covered person when a contract
5 between a health care provider and the managed care entity is terminated for cause.
6 (g) If a contract between a health care provider and a managed care entity is
7 terminated, a covered person may continue to be treated by that health care provider
8 as provided in this subsection. If a covered person is pregnant or being actively
9 treated by a provider on the date of the termination of the contract between that
10 provider and the managed care entity, the covered person may continue to receive
11 health care services from that provider as provided in this subsection, and the contract
12 between the managed care entity and the provider shall remain in force with respect
13 to the continuing treatment. The covered person shall be treated for the purposes of
14 benefit determination or claim payment as if the provider were still under contract with
15 the managed care entity. However, treatment is required to continue only while the
16 group managed care plan remains in effect and
17 (1) for the period that is the longest of the following:
18 (A) the end of the current plan year;
19 (B) up to 90 days after the termination date, if the event
20 triggering the right to continuing treatment is part of an ongoing course of
21 treatment; or
22 (C) through completion of postpartum care, if the covered
23 person is in the second trimester of pregnancy on the date of termination; or
24 (2) until the end of the medically necessary treatment for the condition,
25 disease, illness, or injury if the person has a terminal condition, disease, illness, or
26 injury; in this paragraph, "terminal" means a life expectancy of less than one year.
27 (h) The requirements of this section do not apply to health care services
28 covered by Medicaid.
29 **Sec. 21.07.040. Confidentiality of managed care information.** (a) Medical
30 and financial information in the possession of a managed care entity regarding an
31 applicant or a current or former person covered by a managed care plan is confidential

ok ok ok ok ok ok ok ok ok

1 and is not subject to public disclosure.
2 (b) This section does not apply to medical information that is disclosed if
3 (1) the individual whose identity is disclosed gives written consent to
4 the disclosure;
5 (2) the information is disclosed for research purposes using
6 (A) medical information that is subject to federal law protecting
7 the rights and welfare of research participants; or
8 (B) anonymous health information in which the confidentiality
9 of participants is protected by coding or encryption of information that would
10 otherwise reveal the identity of the patient;
11 (3) the information is disclosed for purposes of obtaining
12 reimbursement under health insurance;
13 (4) the information is disclosed at the written request of the covered
14 person.
15 **Sec. 21.07.050. External health care appeals.** (a) A managed care entity
16 offering group health insurance coverage shall provide for an external appeal process
17 that meets the requirements of this section in the case of an externally appealable
18 decision for which a timely appeal is made in writing either by the managed care
19 entity or by the enrollee.
20 (b) A managed care entity may condition the use of an external appeal process
21 in the case of an externally appealable decision upon a final decision in an internal
22 appeal under AS 21.07.020, but only if the decision is made in a timely basis
23 consistent with the deadlines provided under this chapter.
24 (c) Except as provided in this subsection, the external appeal process shall be
25 conducted under a contract between the managed care entity and one or more external
26 appeal agencies that have qualified under AS 21.07.060. The managed care entity
27 shall provide
28 (1) that the selection process among external appeal agencies qualifying
29 under AS 21.07.060 does not create any incentives for external appeal agencies to
30 make a decision in a biased manner;
31 (2) for auditing a sample of decisions by external appeal agencies to

ok
ok
ok
insert version (c) ok
ok
ok

1 assure that decisions are not made in a biased manner; and

2 (3) that all costs of the process, except those incurred by the enrollee

3 or treating professional in support of the appeal, shall be paid by the managed care

4 entity and not by the enrollee.

5 (e) (d) An external appeal process must include at least the following:

6 (1) a fair, de novo determination based on coverage provided by the

7 plan and by applying terms as defined by the plan; however, nothing in this paragraph

8 may be construed as providing for coverage of items and services for which benefits

9 are excluded under the plan or coverage;

10 (2) an external appeal agency shall determine whether the managed care

11 entity's decision is (A) in accordance with the medical needs of the patient involved.

12 as determined by the managed care entity, taking into account, as of the time of the

13 managed care entity's decision, the patient's medical needs and any relevant and

14 reliable evidence the agency obtains under (3) of this subsection, and (B) in

15 accordance with the scope of the covered benefits under the plan; if the agency

16 determines the decision complies with this paragraph, the agency shall affirm the

17 decision, and, to the extent that the agency determines the decision is not in

18 accordance with this paragraph, the agency shall reverse or modify the decision;

19 (2) (3) the external appeal agency shall include among the evidence taken

20 into consideration

21 (A) the decision made by the managed care entity upon internal

22 appeal under AS 21.07.020 and any guidelines or standards used by the

23 managed care entity in reaching a decision;

24 (B) any personal health and medical information supplied with

25 respect to the individual whose denial of claim for benefits has been appealed;

26 (C) the opinion of the individual's treating physician or health

27 care provider; and

28 (D) the group managed care plan;

29 (4) the external appeal agency may also take into consideration the

30 following evidence: but is not limited to

31 (A) the results of studies that meet professionally recognized

O/C

O/C

Keep version (K)(2)(3) pg 10, lines 15-28

O/C

O/C with change

1 standards of validity and replicability or that have been published in peer-
2 reviewed journals;
3 (B) the results of professional consensus conferences conducted
4 or financed in whole or in part by one or more government agencies;
5 (C) practice and treatment guidelines prepared or financed in
6 whole or in part by government agencies;
7 (D) government-issued coverage and treatment policies;
8 (E) generally accepted principles of professional medical
9 practice; Community standard of care
10 (F) to the extent that the agency determines it to be free of any
11 conflict of interest, the opinions of individuals who are qualified as experts in
12 one or more fields of health care that are directly related to the matters under
13 appeal; and
14 (G) to the extent that the agency determines it to be free of any
15 conflict of interest, the results of peer reviews conducted by the managed care
16 entity involved;
17 (5) an external appeal agency shall determine
18 (A) whether a denial of a claim for benefits is an externally
19 appealable decision;
20 (B) whether an externally appealable decision involves an
21 expedited appeal; and
22 (C) for purposes of initiating an external review, whether the
23 internal appeal process has been completed;
24 (6) a party to an externally appealable decision may submit evidence
25 related to the issues in dispute;
26 (7) the managed care entity involved shall provide the external appeal
27 agency with access to information and to provisions of the plan or health insurance
28 coverage relating to the matter of the externally appealable decision, as determined by
29 the external appeal agency; and
30 (8) a determination by the external appeal agency on the decision must
31 (A) be made orally or in writing and, if it is made orally, shall

OK
ok with change
OK
OK

1 be supplied to the parties in writing as soon as possible;
2 (B) be made in accordance with the medical exigencies of the
3 case involved, but in no event later than 21 working days after the appeal is
4 filed, or, in the case of an expedited appeal, 72 hours after the time of
5 requesting an external appeal of the managed care entity's decision;
6 (C) state, in layperson's language, the basis for the
7 determination, including, if relevant, any basis in the terms or conditions of the
8 plan or coverage; and
9 (D) inform the enrollee of the individual's rights, including any
10 time limits, to seek further review by the courts of the external appeal
11 determination.
12 (e) If the external appeal agency reverses or modifies the denial of a claim for
13 benefits, the managed care entity shall
14 (1) upon receipt of the determination, authorize benefits in accordance
15 with that determination;
16 (2) take action as may be necessary to provide benefits, including items
17 or services, in a timely manner consistent with the determination; and
18 (3) submit information to the external appeal agency documenting
19 compliance with the agency's determination.
20 (f) A decision of an external appeal agency is binding unless a person who is
21 aggrieved by a final decision of an external appeal agency appeals the decision to the
22 superior court.
23 (g) An appeal of a final decision of an external appeal agency must be filed
24 within six months after the date of the decision of the external appeal agency.
25 (h) In this section, "externally appealable decision"
26 (1) means
27 (A) a denial of a claim for benefits that is based in whole or in
28 part on a decision that the item or service is not medically necessary or
29 appropriate or is investigational or experimental, or in which the decision as to
30 whether a benefit is covered involves a medical judgment; or
31 (B) a denial that is based on a failure to meet an applicable

ok
ok
ok
ok
ok
ok

1 deadline for internal appeal under AS 21.07.020;
2 (2) does not include a decision based on specific exclusions or express
3 limitations on the amount, duration, or scope of coverage that do not involve medical
4 judgment, or a decision regarding whether an individual is a participant, beneficiary,
5 or enrollee under the plan or coverage.
6 **Sec. 21.07.060. Qualifications of external appeal agencies.** (a) An external
7 appeal agency qualifies to consider external appeals if, with respect to a group health
8 plan, the agency is certified by a qualified private standard-setting organization
9 approved by the director or by a health insurer operating in this state as meeting the
10 requirements imposed under (b) of this section.
11 (b) An external appeal agency is qualified to consider appeals of group health
12 plan health care decisions if the agency meets the following requirements:
13 (1) the agency meets the independence requirements of this section;
14 (2) the agency conducts external appeal activities through a panel of
15 clinical peers; and
16 (3) the agency has sufficient medical, legal, and other expertise and
17 sufficient staffing to conduct external appeal activities for the managed care entity on
18 a timely basis consistent with this chapter.
19 (c) A clinical peer or other entity meets the independence requirements of this
20 section if
21 (1) the peer or entity does not have a familial, financial, or professional
22 relationship with a related party;
23 (2) compensation received by a peer or entity in connection with the
24 external review is reasonable and not contingent on any decision rendered by the peer
25 or entity;
26 (3) the plan and the issuer have no recourse against the peer or entity
27 in connection with the external review; and
28 (4) the peer or entity does not otherwise have a conflict of interest with
29 a related party.
30 (d) In this section, "related party" means
31 (1) with respect to

ok
ok
we need a number, don't leave it open
ok
ok
ok
ok
ok
ok
ok

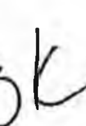
1 (A) a group health plan or health insurance coverage offered in
2 connection with a plan, the plan or the insurer offering the coverage; or
3 (B) individual health insurance coverage, the insurer offering
4 the coverage, or any plan sponsor, fiduciary, officer, director, or management
5 employee of the plan or issuer;
6 (2) the health care professional that provided the health care involved
7 in the coverage decision;
8 (3) the institution at which the health care involved in the coverage
9 decision is provided;
10 (4) the manufacturer of any drug or other item that was included in the
11 health care involved in the coverage decision;
12 (5) the covered person; or
13 (6) any other party that, under the regulations that the director may
14 prescribe, is determined by the director to have a substantial interest in the coverage
15 decision.

ok

16 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal
17 agency qualifying under AS 21.07.060 and having a contract with a managed care
18 entity, and a person who is employed by the agency or who furnishes professional
19 services to the agency, may not be held by reason of the performance of any duty,
20 function, or activity required or authorized under this chapter to have violated any
21 criminal law, or to be civilly liable if due care was exercised in the performance of the
22 duty, function or activity and there was no actual malice or gross misconduct in the
23 performance of the duty, function, or activity.

ok

24 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be
25 construed to
26 (1) restrict or limit the right of a managed care entity to include health
27 care services provided by a religious nonmedical provider as health care services
28 covered by the managed care plan;



29 (2) require a managed care entity, when determining coverage for
30 health care services provided by a religious nonmedical provider, to
31 (A) apply medically based eligibility standards;

1 (B) use health care providers to determine access by a covered
2 person;
3 (C) use health care providers in making a decision on an
4 internal or external appeal; or
5 (D) require a covered person to be examined by a health care
6 provider as a condition of coverage; or
7 (3) require a managed care plan to exclude coverage for health care
8 services provided by a religious nonmedical provider because the religious nonmedical
9 provider is not providing medical or other data required from a health care provider
10 if the medical or other data is inconsistent with the religious nonmedical treatment or
11 nursing care being provided.
12 **Sec. 21.07.250. Definitions.** In this chapter,
13 (1) "clinical peer" means a health care provider who is licensed to
14 provide the same or similar health care services and who is trained in the specialty or
15 subspecialty applicable to the health care services that are provided;
16 (2) "clinical trial" means treatment, research, study, or investigation
17 over a period of time of an injury, illness, or medical condition;
18 (3) "emergency room services" means health care services provided by
19 a hospital or other emergency facility after the sudden onset of a medical condition
20 that manifests itself by symptoms of sufficient severity, including severe pain, that the
21 absence of immediate medical attention would reasonably be expected by a prudent
22 person who possesses an average knowledge of health and medicine to result in
23 (A) the placing of the person's health in serious jeopardy;
24 (B) a serious impairment to bodily functions; or
25 (C) a serious dysfunction of a bodily organ or part;
26 (4) "group managed care plan" or "plan" means a group health
27 insurance plan operated by a managed care entity;
28 (5) "health care provider" means a person licensed in this state or
29 another state of the United States to provide health care services;
30 (6) "health care services" means treatment of an individual for an
31 injury, illness, or disability and includes preventative treatment of an injury or illness;

ok

ok

1 (7) "health insurance" has the meaning given in AS 21.12.050(a);
2 (8) "managed care" means a contract given to an individual, family, or
3 group of individuals under which a member is entitled to receive a defined set of
4 health care benefits in exchange for defined consideration and that requires the member
5 to comply with utilization review guide lines; "managed care" does not include
6 Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);
7 (9) "managed care contractor" means a contractor who establishes,
8 operates, or maintains a network of participating health care providers, conducts or
9 arranges for utilization review activities, and contracts with a managed care entity;
10 (10) "managed care entity" means an insurer, a hospital or medical
11 service corporation, a health maintenance organization, an employer or employee
12 health care organization, a managed care contractor that operates a group managed care
13 plan, or a person who has a financial interest in health care services provided to an
14 individual;
15 (11) "medical emergency" means the sudden onset of a medical
16 condition that manifests itself by symptoms of sufficient severity, including severe pain
17 that in the absence of immediate medical attention would reasonably be expected by
18 a prudent person who possesses an average knowledge of health and medicine to result
19 in
20 (A) the placing of the person's health in serious jeopardy;
21 (B) a serious impairment to bodily functions; or
22 (C) a serious dysfunction of any bodily organ or part;
23 (12) "participating health care provider" means a health care provider
24 who has entered into an agreement with a managed care entity to provide services or
25 supplies to a patient covered by a group managed care plan;
26 (13) "primary care provider" means a health care provider who provides
27 general health care services and does not specialize in treating a single injury, illness,
28 or condition or who provides obstetrical, gynecological, or pediatric health care
29 services;
30 (14) "provider" means a health care provider;
31 (15) "religious nonmedical provider" means a person who does not

must include "medical necessity" definition (K) version

ok

ok

ok

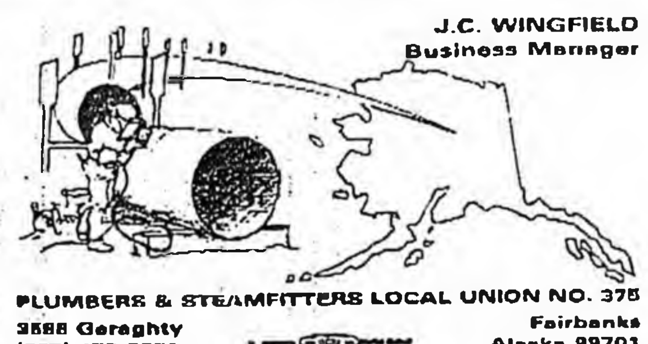
ok

1 provide medical care, but who provides only religious nonmedical treatment or nursing
2 care for an illness or injury;
3 (16) "utilization review" means a system of reviewing the medical
4 necessity, appropriateness, or quality of health care services and supplies provided
5 under a group managed care plan using specified guidelines, including preadmission
6 certification, the application of practice guidelines, continued stay review, discharge
7 planning, preauthorization of ambulatory procedures, and retrospective review;
8 (17) "working day" means a day of the week that is not a Saturday,
9 Sunday, or a holiday.
10 * Sec. 3. AS 21.36.125 is amended by adding a new paragraph to read:
11 (16) violate a provision contained in AS 21.07.
12 * Sec. 4. The uncodified law of the State of Alaska is amended by adding a new section
13 to read:
14 INDIRECT COURT RULE AMENDMENT. AS 21.07.050(g), as enacted by sec. 2
15 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by
16 providing that an appeal from a decision of an external appeal agency must be filed within
17 six months of the decision of the external appeal agency.

18 * Sec. 5. The uncodified law of the State of Alaska is amended by adding a new section
19 to read:
20 CONDITIONAL EFFECT. AS 21.07.050(g), as enacted by sec. 2 of this Act, takes
21 effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required
22 by art. IV, sec. 15, Constitution of the State of Alaska.

23 * Sec. 6. This Act takes effect July 1, 2001.

J.C. WINGFIELD
Business Manager



PLUMBERS & STEAMFITTERS LOCAL UNION NO. 375
3568 Geraghty
(907) 479-6221
Fairbanks
Alaska 99701

SENT BY FAX

DATE 4/3/00 FAX Number 465-2819

Total # of pages: 2 Call 479-6221 to correct problems w/transmission

FROM: U.A. Local 375 of the Plumbers & Steamfitters Union
3568 Geraghty Street
Fairbanks, Alaska 99709
Telephone: 907-479-6221

TO: Representative Kott

Route to:

CC:

Comments:

UNITED ASSOCIATION
of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada

Founded 1889

Martin J. Maddaloni
General President

Michael A. Collins
General Secretary-Treasurer

C. Randal Gardner
Assistant General President

Letters should be confined to one subject

UA Local Union: 375
3568 Geraghty Street, Fairbanks, Alaska 99709

Subject:

March 31, 2000

Representative Pete Kott

We, the trustees of Plumbers & Steamfitters Local 375 H & W Fund, representing approximately 500 Plan Participants, have read and reviewed House Bill #211, sponsored by Representative Norm Rokeberg. Its passing will have a significant and adverse impact on our Participants' health care costs.

If we are faced with the decision to either increase exposure to participant litigation or be denied the ability to control plan costs through effective managed care, we will not be able to afford to continue providing our plan participants with the level of benefits they currently enjoy. Managed care is one method we can use to control the increasing cost of health care.

You should be aware that as Trustees and Plan Sponsors, we are the ones who create the Plan design and the cost containment provisions of the plan- not the insurance company.

Again, House Bill 211, if passed, will be disadvantage to our Plan participants and Plan Fiduciaries. Therefore, we strongly encourage the defeat of House Bill #211.

Sincerly,

J. L. Wingfield

Chairman of The Board of Trustees

TOTAL P.02

Alaska State Legislature

HOUSE OF REPRESENTATIVES

Official Business faxed to Legal 4/4/00 @ 7:50pm jp

State Capitol
Juneau, AK 99801-1182

MEMORANDUM **TIME SENSITIVE, SEE PARAGRAPH 2**

TO: Mike Ford, Legislative Counsel **FAX:** 2029

FROM: Janet Seitz Janet
Rep. Norman Rokeberg's Office

DATE: April 4, 2000

RE: HB 211 - N version

At the request of Rep. Joe Green, Chair, Subcommittee on HB 211, I am requesting a new work draft CS, blank committee sponsor, as contained in this memorandum. Please use the N version, LS0472/N, Ford, 3/30/00 as your starting point.

Please NOTE that the subcommittee is scheduled to report to the full House Judiciary Committee regarding this matter at the Wednesday, April 5th, meeting, which begins at 1:00 p.m. It would be appreciated if we could have the work draft BEFORE the meeting.

1. Amendment #1, use LS0472/N.1, Ford, 3/31/00
2. Page 2, line 9, after "within" DELETE "14"; INSERT "10"
3. Amendment #2, see "Rokeberg A" follows. Use the amendments to Page 3, line 8, and page 3, line 15 as reflected by that amendment. DO NOT incorporate the page 3, line 9, amendment.
4. Amendment #3, see "Rokeberg B" follows. Note that the correct line reference is line 26, page 3.

3. Amendment #4, see "Rokeberg C" as follows.

4. Amendment #5, see "Rokeberg D" as follows.

5. Amendment #6, page 5, line 7, after "deductible", DELETE "or"; INSERT ",". Page 5, line 8, after "copayment", DELETE "and"; INSERT "or".

6. Amendment #7, page 11, lines 14-15, conceptual amendment: (2) Unless otherwise agreed to by both parti the agency conducts external appeal activities through a panel of twc nical peers; and

7. Page 3, line 2, INSERT new subsection (1) as follows:

   Provides a reasonable mechanism to identify all health care services to be covered by the managed care entity;

   Renumber remaining sections.

8. Page 4, line 11, after "within" DELETE "20"; INSERT "18".

9. Page 4, lines 26-27: DELETE language and replace with:

   A provision describing a mechanism for assignment of benefits for health care providers and payment of benefits.

10. Page 4, line 29, after "guide," DELETE "and its structure" and INSERT "and whether drugs not listed are excluded."

11. Page 5, line 8 after "plan", INSERT conceptual amendment: "subject to the terms of AS 21.54.015." Please verify that the director of insurance has adequate authority to review rates of the managed care entity and request information if the review indicates a problem. Hospital or medical service corporations already have to file with the director under AS 21.87.190 and we desire to reference those who may not file yearly rates.

12. Page 5, line 31 after "health care providers" INSERT: as set forth in the applicable member contract.

    AFTER that new language add: "The non-network option may require that a covered person pay a higher deductible, copayment or a higher premium for the plan."

13. Page 9, line 16: ADD two more subsections as follows:

    (H) community standard of care;
    (I) anomalous utilization patterns.

2/8

If you have any questions, please do not hesitate to contact me at x4954 or Kevin Jardell of Rep. Green's office at x4931. A copy of the work draft should be delivered to both offices.

cc: Kevin Jardell, Rep. Green's Office

3/8

1-LS0472\N.1
Ford
3/31/00

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 211( ), Draft Version "N"

1 Page 4, line 11, following "decision":
2 Insert "(A)"

3 Page 4, line 12, following "received;":
4 Insert "and
5 (B) on the appeal by an employee or agent of the managed care
6 entity who holds the same professional license as the health care provider who
7 is treating the covered person;"

8 Page 4, line 17, following "shall":
9 Insert "(A)"

10 Page 4, line 18, following "appeal;":
11 Insert "and
12 (B) provide for a written decision on the appeal by an
13 employee or agent of the managed care entity who holds the same professional
14 license as the health care provider who is treating the covered person;"

L

4/8

Rokeberg A

AMENDMENT # 2

OFFERED IN THE HOUSE By: Rep. Rokeberg

TO: CSHB 201 (), LS0472/N, Ford, 3/30/00

Page 3, line 8

AFTER: "provider to"
DELETE: "purchase or use"
INSERT: "contract for"

RATIONALE: The provider does not purchase or use the product; the patient does. The provider, therefore, contracts for the products.

Page 3, line 9:

AFTER: "entity"

INSERT: unless these products have equal rates of provider compensation.

RATIONALE: Requested by Blue Cross. Allows access to products that provider may want.

NO

Page 3, line 15:

AFTER: "entity"

INSERT: "for the acts of the managed care entity"

RATIONALE: As written, the language would prohibit the standard clauses in which the provider indemnifies the entity for the provider's bad acts and the entity indemnifies the provider for the entity's bad acts. New language would make it clear that contract could not include a provision where the provider would hold the entity harmless for the entity's bad act.

5/8

adopted

Rokeberg B

AMENDMENT 3

OFFERED IN THE HOUSE By: Rokeberg

TO: CSHB 211 (), LS0472/N, Ford, 3/30/00

Page 3, line ~~25~~ 26:

AFTER: "referrals"

INSERT: ", if required,"

RATIONALE: Some plans do not require a patient to receive referrals. The current language would mandate that a plan must have a referral system. If a plan does not have a referral system, there should be no mandate to put one in place.

6/8

adopted

Rokeberg C

AMENDMENT # 4

OFFERED IN THE HOUSE BY: ROKEBERG

TO: CSHB 211 (), LS0472/N, Ford, 3/30/00

Page 6, lines 4-5:

DELETE

Reletter subsequent sections

RATIONALE: This clause would mean that every time a provider contract was terminated, the entity would have to notify all covered persons. This is a cost driver as it could result in many letters being sent out to notify all covered persons.

Additionally, the language references "for cause" and putting this in a letter could create liability for the managed care entity.

7/8

adopted

Rokeberg D

AMENDMENT # 6

OFFERED IN THE HOUSE BY ROKEBERG

TO: CSHB 211 (), LS0427/N

Page 7, lines 5-10 DELETE current language and insert following:

(2) the information is disclosed for research:
  (A) that is subject to federal laws and regulations protecting the rights and welfare of research participants; or
  (B) using health information that protects the confidentiality of participants by coding or encryption of information that would otherwise identify the patient.

RATIONALE: Code of Federal Regulations specifically outlines the protections required and procedures to protect patients that must be used by institutional Review Boards, researchers, and clinical sites. Other federal laws given general guidance. Thus "federal laws and regulations" is the correction terminology to include all provisions followed by researchers to ensure patient protection.

Information that is coded and encrypted is not truly anonymous - the encryption code or key and be used to identify the patient in situations where the patients is in danger or when the patient's physician believes it is necessary. This amendment in (b) more clearly exempts the type of information that should be exempted, without mis-characterizing it as anonymous.

Page 7, line 14:

AFTER: "person"
INSERT: ";
  (5) such disclosure is required by law.

RATIONALE: This would cover such items as court orders to disclose.

8/8

1-LS0472\N.1
Ford
3/31/00

A M E N D M E N T

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 211( ), Draft Version "N"

1 Page 4, line 11, following "decision":
2 Insert "(A)"

3 Page 4, line 12, following "received;":
4 Insert "and
5 (B) on the appeal by an employee or agent of the managed care
6 entity who holds the same professional license as the health care provider who
7 is treating the covered person;"

8 Page 4, line 17, following "shall":
9 Insert "(A)"

10 Page 4, line 18, following "appeal;":
11 Insert "and
12 (B) provide for a written decision on the appeal by an
13 employee or agent of the managed care entity who holds the same professional
14 license as the health care provider who is treating the covered person;"

1-LS0472\N.2
Ford
3/31/00

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE ROKEBERG

TO: CSHB 211( ), Draft Version "N"

1 Page 3, following line 18:
2 Insert a new paragraph to read:
3 "(1) a provision that defines "medical necessity"; unless the plan sets
4 out a different definition, "medical necessity" shall be defined as meaning those health
5 care services or products that a prudent physician would provide to a patient for the
6 purpose of preventing, diagnosing, or treating an illness, injury, disease, or its
7 symptoms in a manner that is
8 (A) consistent with generally accepted standards of medical
9 practice;
10 (B) clinically appropriate in terms of type, frequency, extent,
11 site, and duration; and
12 (C) not primarily for the convenience of the patient, physician,
13 or other health care provider;"

14 Renumber the following paragraphs accordingly.

15 Page 4, line 10:
16 Delete "(6)"
17 Insert "(7)"

Rokeberg A

AMENDMENT #_____

OFFERED IN THE HOUSE By: Rep. Rokeberg

TO: CSHB 201 (), LS0472/N, Ford, 3/30/00

Page 3, line 8

AFTER: "provider to"
DELETE: "purchase or use"
INSERT: "contract for"

RATIONALE: The provider does not purchase or use the product; the patient does. The provider, therefore, contracts for the products.

Page 3, line 9:

AFTER: "entity"

INSERT: unless these products have equal rates of provider compensation.

RATIONALE: Requested by Blue Cross. Allows access to products that provider may want.

Page 3, line 15:

AFTER: "entity"

INSERT: "for the acts of the managed care entity"

RATIONALE: As written, the language would prohibit the standard clauses in which the provider indemnifies the entity for the provider's bad acts and the entity indemnifies the provider for the entity's bad acts. New language would make it clear that contract could not include a provision where the provider would hold the entity harmless for the entity's bad act.

Rokeberg B

AMENDMENT ______

OFFERED IN THE HOUSE By: Rokeberg

TO: CSHB 211 (), LS0472/N, Ford, 3/30/00

Page 3, line 25:

AFTER: "referrals"

INSERT: ", if required,"

RATIONALE: Some plans do not require a patient to receive referrals. The current language would mandate that a plan must have a referral system. If a plan does not have a referral system, there should be no mandate to put one in place.

Rokeberg C

AMENDMENT #____

OFFERED IN THE HOUSE BY: ROKEBERG

TO: CSHB 211 (), LS0472/N, Ford, 3/30/00

Page 6, lines 4-5:

DELETE

Reletter subsequent sections

RATIONALE: This clause would mean that every time a provider contract was terminated, the entity would have to notify all covered persons. This is a cost driver as it could result in many letters being sent out to notify all covered persons.

Additionally, the language references "for cause" and putting this in a letter could create liability for the managed care entity.

Rokeberg D

AMENDMENT #_____

OFFERED IN THE HOUSE BY ROKEBERG

TO: CSHB 211 (), LS0427/N

Page 7, lines 5-10 DELETE current language and insert following:

(2) the information is disclosed for research:
(A) that is subject to federal laws and regulations protecting the rights and welfare of research participants; or
(B) using health information that protects the confidentiality of participants by coding or encryption of information that would otherwise identify the patient.

RATIONALE: Code of Federal Regulations specifically outlines the protections required and procedures to protect patients that must be used by institutional Review Boards, researchers, and clinical sites. Other federal laws given general guidance. Thus "federal laws and regulations" is the correction terminology to include all provisions followed by researchers to ensure patient protection.

Information that is coded and encrypted is not truly anonymous - the encryption code or key and be used to identify the patient in situations where the patients is in danger or when the patient's physician believes it is necessary. This amendment in (b) more clearly exempts the type of information that should be exempted, without mis-characterizing it as anonymous.

Page 7, line 14:

AFTER: "person"
INSERT: ";
(5) such disclosure is required by law.

RATIONALE: This would cover such items as court orders to disclose.

ensure that an independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute.

(4) Carriers must provide to the appropriate certified independent review organization, not later than the third business day after the date the carrier receives a request for review, a copy of:

(a) Any medical records of the enrollee that are relevant to the review;

(b) Any documents used by the carrier in making the determination to be reviewed by the certified independent review organization;

(c) Any documentation and written information submitted to the carrier in support of the appeal; and

(d) A list of each physician or health care provider who has provided care to the enrollee and who may have medical records relevant to the appeal. Health information or other confidential or proprietary information in the custody of a carrier may be provided to an independent review organization, subject to rules adopted by the commissioner.

(5) The medical reviewers from a certified independent review organization will make determinations regarding the medical necessity or appropriateness of, and the application of health plan coverage provisions to, health care services for an enrollee. The medical reviewers' determinations must be based upon their expert medical judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of ~~Washington~~ Alaska. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the medical coverage agreement. Medical reviewers may override the health plan's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based medical practice.

(6) Once a request for an independent review determination has been made, the independent review organization must proceed to a final determination, unless requested otherwise by both the carrier and the enrollee or the enrollee's representative.

(7) Carriers must timely implement the certified independent review organization's determination, and must pay the certified independent review organization's charges.

(8) When an enrollee requests independent review of a dispute under this section, and the dispute involves a carrier's decision to modify, reduce, or terminate an otherwise covered health service that an enrollee is receiving at the time the request for review is submitted and the carrier's decision is based upon a finding that the health service, or level of health service, is no longer medically necessary or appropriate, the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.

(9) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by a carrier.

From Wash state

STATE OF ALASKA

TONY KNOWLES, GOVERNOR

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

1031 WEST 4TH AVENUE, SUITE 200
ANCHORAGE, ALASKA 99501-5903
PHONE: (907)269-5100
FAX: (907)276-3697

April 6, 2000

VIA FACSIMILE

The Honorable Norm Rokeberg
House of Representatives
State Capitol
Juneau AK 99801-1182

Re: HB 211

Dear Representative Rokeberg:

This letter confirms my discussion with Janet Seitz regarding the authority of the director for the division of insurance over health insurance rates.

As you know, health insurers are not required to make rate filings with the division of insurance under AS 21.39, except that hospital and medical service corporations like Blue Cross are required to file all rate information before changing its rates pursuant to AS 21.87.190. The director, however, does have authority to request and ultimately review any information from health insurers to the extent it may be relevant to an investigation or examination under the insurance code.

Pursuant to AS 21.06.080, the director has the authority to conduct investigations or examinations to determine if an insurer has violated any provision of the insurance code or "to secure information useful in the lawful administration of the insurance code." Under AS 21.06.120, the director has the specific authority to review the affairs, transactions, accounts, records, and assets of each authorized insurer. Under this authority, the director conducts examination of the financial condition and market practices of insurers, which could include examination of rates. Both of these statutes represent authority upon which the director may rely to review rates of a health insurer.

For example, if a health insurer's practice with respect to rates appears to violate AS 21.36.030 relating to misrepresentation in the sale of insurance policies or AS 21.36.100 relating to rebating, the director has authority to request, or if necessary, subpoena rate information from the insurer to determine if there has been a violation. Another example and perhaps more relevant relates to AS 21.54.015, which provides that "[r]ates for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory." To determine

compliance with this provision, the director has the authority to request documents or examine the records of the insurer related to its rating plans and practices. In addition, the adequacy of rates could have a bearing on the financial solvency of an insurer, which may be another basis to examine rates under the authority of AS 21.06.120.

The director does not have express authority to routinely request rate information from health insurers. To the extent you want the director to routinely obtain and review health insurer rate information, then this is best accomplishment by a change in statute. Such a statutory change, however, may have fiscal implications to the division of insurance because it would require the division to obtain information and perform reviews that it does not do now.

Very truly yours,

BRUCE M. BOTELHO
ATTORNEY GENERAL

By: Signe P. Andersen
Signe P. Andersen
Assistant Attorney General

cc: Robert A. Lohr, Director

1-LS0472\N
Ford
3/30/00

adopted 3/31/00

CS FOR HOUSE BILL NO. 211( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): REPRESENTATIVE ROKEBERG BY REQUEST

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to regulation of managed care insurance plans; amending Rule**
2 **602(b), Alaska Rules of Appellate Procedure; and providing for an effective date."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** The uncodified law of the State of Alaska is amended by adding a new
5 section to read:
6 SHORT TITLE. Section 2 of this Act may be known as the Alaska Patients' Bill of
7 Rights.
8 *** Sec. 2.** AS 21 is amended by adding a new chapter to read:
9 **Chapter 07. Regulation of Managed Care Insurance Plans.**
10 **Sec. 21.07.010. Patient and health care provider protection.** (a) A contract
11 between a participating health care provider and a managed care entity that offers a
12 group managed care plan must contain a provision that
13 (1) clearly states or references an attachment that states the health care
14 provider's rate of compensation;

1 and is not subject to public disclosure.
2 (b) This section does not apply to medical information that is disclosed if
3 (1) the individual whose identity is disclosed gives written consent to
4 the disclosure;
5 (2) the information is disclosed for research purposes using
6 (A) medical information that is subject to federal law protecting
7 the rights and welfare of research participants; or
8 (B) anonymous health information in which the confidentiality
9 of participants is protected by coding or encryption of information that would
10 otherwise reveal the identity of the patient;
11 (3) the information is disclosed for purposes of obtaining
12 reimbursement under health insurance;
13 (4) the information is disclosed at the written request of the covered
14 person.
15 **Sec. 21.07.050. External health care appeals.** (a) A managed care entity
16 offering group health insurance coverage shall provide for an external appeal process
17 that meets the requirements of this section in the case of an externally appealable
18 decision for which a timely appeal is made in writing either by the managed care
19 entity or by the enrollee.
20 (b) A managed care entity may condition the use of an external appeal process
21 in the case of an externally appealable decision upon a final decision in an internal
22 appeal under AS 21.07.020, but only if the decision is made in a timely basis
23 consistent with the deadlines provided under this chapter.
24 (c) Except as provided in this subsection, the external appeal process shall be
25 conducted under a contract between the managed care entity and one or more external
26 appeal agencies that have qualified under AS 21.07.060. The managed care entity
27 shall provide
28 (1) that the selection process among external appeal agencies qualifying
29 under AS 21.07.060 does not create any incentives for external appeal agencies to
30 make a decision in a biased manner;
31 (2) for auditing a sample of decisions by external appeal agencies to

1 (2) clearly states all ways in which the contract between the health care
2 provider and managed care entity may be terminated; a provision that provides for
3 discretionary termination by either party must apply equitably to both parties;
4 (3) provides that, in the event of a dispute between the parties to the
5 contract, a fair, prompt, and mutual dispute resolution process must be used; at a
6 minimum, the process must provide
7 (A) for an initial meeting at which all parties are present or
8 represented by individuals with authority regarding the matters in dispute; the
9 meeting shall be held within 14 working days after the plan receives written
10 notice of the dispute or gives written notice to the provider, unless the parties
11 otherwise agree in writing to a different schedule;
12 (B) that if, within 30 days following the initial meeting, the
13 parties have not resolved the dispute, the dispute shall be submitted to
14 mediation directed by a mediator who is mutually agreeable to the parties and
15 who is not regularly under contract to or employed by either of the parties;
16 each party shall bear its proportionate share of the cost of mediation, including
17 the mediator fees;
18 (C) that if, after a period of 60 days following commencement
19 of mediation, the parties are unable to resolve the dispute, either party may
20 seek other relief allowed by law;
21 (D) that the parties shall agree to negotiate in good faith in the
22 initial meeting and in mediation;
23 (4) states that a health care provider may not be penalized or the health
24 care provider's contract terminated by the managed care entity because the health care
25 provider acts as an advocate for a covered person in seeking appropriate, medically
26 necessary health care services;
27 (5) protects the ability of a health care provider to communicate openly
28 with a covered person about all appropriate diagnostic testing and treatment options;
29 and
30 (6) defines words in a clear and concise manner.
31 (b) A contract between a participating health care provider and a managed care

1 entity that offers a group managed care plan may not contain a provision that
2 (1) has as its predominant purpose the creation of direct financial
3 incentives to the health care provider for withholding covered health care services that
4 are medically necessary; nothing in this paragraph shall be construed to prohibit a
5 contract between a participating health care provider and a managed care entity from
6 containing incentives for efficient management of the utilization and cost of covered
7 health care services;
8 (2) requires the provider to purchase or use all products that are
9 currently offered or that may be offered in the future by the managed care entity; and
10 (3) requires the health care provider to be compensated for health care
11 services performed at the same rate as the health care provider has contracted with
12 another managed care entity.
13 (c) A managed care entity may not enter into a contract with a health care
14 provider that requires the provider to indemnify or hold harmless the managed care
15 entity. An indemnification or hold harmless clause entered into in violation of this
16 subsection is void.
17 **Sec. 21.07.020. Required contract provisions for group managed care**
18 **plans.** A group managed care plan must contain
19 (1) a provision that preauthorization for a covered medical procedure
20 on the basis of medical necessity may not be retroactively denied unless the
21 preauthorization is based on materially incomplete or inaccurate information provided
22 by or on behalf of the provider;
23 (2) a provision for emergency room services if any coverage is
24 provided for treatment of a medical emergency;
25 (3) a provision that covered health care services be reasonably available
26 in the community in which a covered person resides or that adequate referrals outside
27 the community be available if the health care service is not available in the
28 community;
29 (4) a provision that any utilization review decision
30 (A) must be made within 72 hours after receiving the request
31 for preapproval for nonemergency situations; for emergency situations,

1 utilization review decisions for care following emergency services must be
2 made as soon as is practicable but in any event no later than 24 hours after
3 receiving the request for preapproval or for coverage determination; and
4 (B) to deny, reduce, or terminate a health care benefit or to
5 deny payment for a health care service because that service is not medically
6 necessary shall be made by an employee or agent of the managed care entity
7 who is a licensed health care provider;
8 (5) a provision that provides for an internal appeal mechanism for a
9 covered person who disagrees with a utilization review decision made by a managed
10 care entity; except as provided under (6) of this section, this appeal mechanism must
11 provide for a written decision from the managed care entity within 20 working days
12 after the date written notice of an appeal is received;
13 (6) a provision that provides for an internal appeal mechanism for a
14 covered person who disagrees with a utilization review decision made by a managed
15 care entity in any case in which delay would, in the written opinion of the treating
16 provider, jeopardize the covered person's life or materially jeopardize the covered
17 person's health; the managed care entity shall decide an appeal described in this
18 paragraph within 72 hours after receiving the appeal;
19 (7) a provision that discloses the existence of the right to an external
20 appeal of a utilization review decision made by a managed care entity; the external
21 appeal shall be as conducted in accordance with AS 21.07.050;
22 (8) a provision that discloses covered benefits, optional supplemental
23 benefits, and benefits relating to and restrictions on nonparticipating provider services;
24 (9) a provision that describes the preapproval requirements and whether
25 clinical trials or experimental or investigational treatment are covered;
26 (10) a provision describing assignment of benefits for health care
27 providers and health care facilities;
28 (11) a provision describing availability of prescription medications or
29 a formulary guide, and its structure; if a formulary guide is made available, the guide
30 must be updated annually; and
31 (12) a provision describing available translation or interpreter services,

1 including audiotape or braille information.

2 **Sec. 21.07.030. Choice of health care provider.** (a) If a managed care entity
3 offers a group health plan that provides for coverage of health care services only if the
4 services are furnished through a network of health care providers that have entered into
5 a contract with the managed care entity, the managed care entity shall also offer a non-
6 network option to enrollees at initial enrollment, as provided under (c) of this section.
7 The non-network option may require that a covered person pay a higher deductible or
8 copayment and a higher premium for the plan. This subsection does not apply to an
9 enrollee who is offered non-network coverage through another group health plan or
10 through another managed care entity in the group market.

11 (b) The amount of any additional premium charged by the managed care entity
12 for the additional cost of the creation and maintenance of the option described in (a)
13 of this section and the amount of any additional cost sharing imposed under this option
14 shall be paid by the enrollee unless it is paid by the employer through agreement with
15 the managed care entity.

16 (c) An enrollee may make a change to the health care coverage option
17 provided under this section only during a time period determined by the managed care
18 entity. The time period described in this subsection must occur at least annually.

19 (d) If a managed care entity that offers a group managed care plan requires or
20 provides for a designation by an enrollee of a participating primary care provider, the
21 managed care entity shall permit the enrollee to designate any participating primary
22 care provider that is available to accept the enrollee.

23 (e) Except as provided in this subsection, a managed care entity that offers a
24 group managed care plan shall permit an enrollee to receive medically necessary or
25 appropriate specialty care, subject to appropriate referral procedures, from any qualified
26 participating health care provider that is available to accept the individual for medical
27 care. This subsection does not apply to specialty care if the managed care entity
28 clearly informs enrollees of the limitations on choice of participating health care
29 providers with respect to medical care. In this subsection,

30 (1) "appropriate referral procedures" means procedures for referring
31 patients to other health care providers

(2) "specialty care" means care provided by a health care provider with training and experience in treating a particular injury, illness, or condition.

(f) A managed care entity shall notify a covered person when a contract between a health care provider and the managed care entity is terminated for cause.

(g) If a contract between a health care provider and a managed care entity is terminated, a covered person may continue to be treated by that health care provider as provided in this subsection. If a covered person is pregnant or being actively treated by a provider on the date of the termination of the contract between that provider and the managed care entity, the covered person may continue to receive health care services from that provider as provided in this subsection, and the contract between the managed care entity and the provider shall remain in force with respect to the continuing treatment. The covered person shall be treated for the purposes of benefit determination or claim payment as if the provider were still under contract with the managed care entity. However, treatment is required to continue only while the group managed care plan remains in effect and

(1) for the period that is the longest of the following:

(A) the end of the current plan year;

(B) up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment; or

(C) through completion of postpartum care, if the covered person is in the second trimester of pregnancy on the date of termination; or

(2) until the end of the medically necessary treatment for the condition, disease, illness, or injury if the person has a terminal condition, disease, illness, or injury; in this paragraph, "terminal" means a life expectancy of less than one year.

(h) The requirements of this section do not apply to health care services covered by Medicaid.

Sec. 21.07.040. Confidentiality of managed care information. (a) Medical and financial information in the possession of a managed care entity regarding an applicant or a current or former person covered by a managed care plan is confidential

assure that decisions are not made in a biased manner; and

(3) that all costs of the process, except those incurred by the enrollee or treating professional in support of the appeal, shall be paid by the managed care entity and not by the enrollee.

(d) An external appeal process must include at least the following:

(1) a fair, de novo determination based on coverage provided by the plan and by applying terms as defined by the plan; however, nothing in this paragraph may be construed as providing for coverage of items and services for which benefits are excluded under the plan or coverage;

(2) an external appeal agency shall determine whether the managed care entity's decision is (A) in accordance with the medical needs of the patient involved, as determined by the managed care entity, taking into account, as of the time of the managed care entity's decision, the patient's medical needs and any relevant and reliable evidence the agency obtains under (3) of this subsection, and (B) in accordance with the scope of the covered benefits under the plan; if the agency determines the decision complies with this paragraph, the agency shall affirm the decision, and, to the extent that the agency determines the decision is not in accordance with this paragraph, the agency shall reverse or modify the decision;

(3) the external appeal agency shall include among the evidence taken into consideration

(A) the decision made by the managed care entity upon internal appeal under AS 21.07.020 and any guidelines or standards used by the managed care entity in reaching a decision;

(B) any personal health and medical information supplied with respect to the individual whose denial of claim for benefits has been appealed;

(C) the opinion of the individual's treating physician or health care provider; and

(D) the group managed care plan;

(4) the external appeal agency may also take into consideration the following evidence:

(A) the results of studies that meet professionally recognized

1 standards of validity and replicability or that have been published in peer-
2 reviewed journals;
3 (B) the results of professional consensus conferences conducted
4 or financed in whole or in part by one or more government agencies;
5 (C) practice and treatment guidelines prepared or financed in
6 whole or in part by government agencies;
7 (D) government-issued coverage and treatment policies;
8 ~~(E) generally accepted principles of professional medical~~
9 practice;
10 (F) to the extent that the agency determines it to be free of any
11 conflict of interest, the opinions of individuals who are qualified as experts in
12 one or more fields of health care that are directly related to the matters under
13 appeal; and
14 (G) to the extent that the agency determines it to be free of any
15 conflict of interest, the results of peer reviews conducted by the managed care
16 entity involved;
17 (5) an external appeal agency shall determine
18 (A) whether a denial of a claim for benefits is an externally
19 appealable decision;
20 (B) whether an externally appealable decision involves an
21 expedited appeal; and
22 (C) for purposes of initiating an external review, whether the
23 internal appeal process has been completed;
24 (6) a party to an externally appealable decision may submit evidence
25 related to the issues in dispute;
26 (7) the managed care entity involved shall provide the external appeal
27 agency with access to information and to provisions of the plan or health insurance
28 coverage relating to the matter of the externally appealable decision, as determined by
29 the external appeal agency; and
30 (8) a determination by the external appeal agency on the decision must
31 (A) be made orally or in writing and, if it is made orally, shall

1 be supplied to the parties in writing as soon as possible;
2 (B) be made in accordance with the medical exigencies of the
3 case involved, but in no event later than 21 working days after the appeal is
4 filed, or, in the case of an expedited appeal, 72 hours after the time of
5 requesting an external appeal of the managed care entity's decision;
6 (C) state, in layperson's language, the basis for the
7 determination, including, if relevant, any basis in the terms or conditions of the
8 plan or coverage; and
9 (D) inform the enrollee of the individual's rights, including any
10 time limits, to seek further review by the courts of the external appeal
11 determination.
12 (e) If the external appeal agency reverses or modifies the denial of a claim for
13 benefits, the managed care entity shall
14 (1) upon receipt of the determination, authorize benefits in accordance
15 with that determination;
16 (2) take action as may be necessary to provide benefits, including items
17 or services, in a timely manner consistent with the determination; and
18 (3) submit information to the external appeal agency documenting
19 compliance with the agency's determination.
20 (f) A decision of an external appeal agency is binding unless a person who is
21 aggrieved by a final decision of an external appeal agency appeals the decision to the
22 superior court.
23 (g) An appeal of a final decision of an external appeal agency must be filed
24 within six months after the date of the decision of the external appeal agency.
25 (h) In this section, "externally appealable decision"
26 (1) means
27 (A) a denial of a claim for benefits that is based in whole or in
28 part on a decision that the item or service is not medically necessary or
29 appropriate or is investigational or experimental, or in which the decision as to
30 whether a benefit is covered involves a medical judgment; or
31 (B) a denial that is based on a failure to meet an applicable

1 deadline for internal appeal under AS 21.07.020;
2 (2) does not include a decision based on specific exclusions or express
3 limitations on the amount, duration, or scope of coverage that do not involve medical
4 judgment, or a decision regarding whether an individual is a participant, beneficiary,
5 or enrollee under the plan or coverage.
6 **Sec. 21.07.060. Qualifications of external appeal agencies.** (a) An external
7 appeal agency qualifies to consider external appeals if, with respect to a group health
8 plan, the agency is certified by a qualified private standard-setting organization
9 approved by the director or by a health insurer operating in this state as meeting the
10 requirements imposed under (b) of this section.
11 (b) An external appeal agency is qualified to consider appeals of group health
12 plan health care decisions if the agency meets the following requirements:
13 (1) the agency meets the independence requirements of this section;
14 (2) the agency conducts external appeal activities through a panel of
15 clinical peers; and
16 (3) the agency has sufficient medical, legal, and other expertise and
17 sufficient staffing to conduct external appeal activities for the managed care entity on
18 a timely basis consistent with this chapter.
19 (c) A clinical peer or other entity meets the independence requirements of this
20 section if
21 (1) the peer or entity does not have a familial, financial, or professional
22 relationship with a related party;
23 (2) compensation received by a peer or entity in connection with the
24 external review is reasonable and not contingent on any decision rendered by the peer
25 or entity;
26 (3) the plan and the issuer have no recourse against the peer or entity
27 in connection with the external review; and
28 (4) the peer or entity does not otherwise have a conflict of interest with
29 a related party.
30 (d) In this section, "related party" means
31 (1) with respect to

1 (A) a group health plan or health insurance coverage offered in
2 connection with a plan, the plan or the insurer offering the coverage; or
3 (B) individual health insurance coverage, the insurer offering
4 the coverage, or any plan sponsor, fiduciary, officer, director, or management
5 employee of the plan or issuer;
6 (2) the health care professional that provided the health care involved
7 in the coverage decision;
8 (3) the institution at which the health care involved in the coverage
9 decision is provided;
10 (4) the manufacturer of any drug or other item that was included in the
11 health care involved in the coverage decision;
12 (5) the covered person; or
13 (6) any other party that, under the regulations that the director may
14 prescribe, is determined by the director to have a substantial interest in the coverage
15 decision.
16 **Sec. 21.07.070. Limitation on liability of reviewers.** An external appeal
17 agency qualifying under AS 21.07.060 and having a contract with a managed care
18 entity, and a person who is employed by the agency or who furnishes professional
19 services to the agency, may not be held by reason of the performance of any duty,
20 function, or activity required or authorized under this chapter to have violated any
21 criminal law, or to be civilly liable if due care was exercised in the performance of the
22 duty, function or activity and there was no actual malice or gross misconduct in the
23 performance of the duty, function, or activity.
24 **Sec. 21.07.080. Religious nonmedical providers.** This chapter may not be
25 construed to
26 (1) restrict or limit the right of a managed care entity to include health
27 care services provided by a religious nonmedical provider as health care services
28 covered by the managed care plan;
29 (2) require a managed care entity, when determining coverage for
30 health care services provided by a religious nonmedical provider, to
31 (A) apply medically based eligibility standards;

1 (B) use health care providers to determine access by a covered
2 person;
3 (C) use health care providers in making a decision on an
4 internal or external appeal; or
5 (D) require a covered person to be examined by a health care
6 provider as a condition of coverage; or
7 (3) require a managed care plan to exclude coverage for health care
8 services provided by a religious nonmedical provider because the religious nonmedical
9 provider is not providing medical or other data required from a health care provider
10 if the medical or other data is inconsistent with the religious nonmedical treatment or
11 nursing care being provided.
12 **Sec. 21.07.250. Definitions.** In this chapter,
13 (1) "clinical peer" means a health care provider who is licensed to
14 provide the same or similar health care services and who is trained in the specialty or
15 subspecialty applicable to the health care services that are provided;
16 (2) "clinical trial" means treatment, research, study, or investigation
17 over a period of time of an injury, illness, or medical condition;
18 (3) "emergency room services" means health care services provided by
19 a hospital or other emergency facility after the sudden onset of a medical condition
20 that manifests itself by symptoms of sufficient severity, including severe pain, that the
21 absence of immediate medical attention would reasonably be expected by a prudent
22 person who possesses an average knowledge of health and medicine to result in
23 (A) the placing of the person's health in serious jeopardy;
24 (B) a serious impairment to bodily functions; or
25 (C) a serious dysfunction of a bodily organ or part;
26 (4) "group managed care plan" or "plan" means a group health
27 insurance plan operated by a managed care entity;
28 (5) "health care provider" means a person licensed in this state or
29 another state of the United States to provide health care services;
30 (6) "health care services" means treatment of an individual for an
31 injury, illness, or disability and includes preventative treatment of an injury or illness;

1 (7) "health insurance" has the meaning given in AS 21.12.050(a);
2 (8) "managed care" means a contract given to an individual, family, or
3 group of individuals under which a member is entitled to receive a defined set of
4 health care benefits in exchange for defined consideration and that requires the member
5 to comply with utilization review guide lines; "managed care" does not include
6 Medicaid coverage under 42 U.S.C. 1396 - 1396p (Social Security Act);
7 (9) "managed care contractor" means a contractor who establishes,
8 operates, or maintains a network of participating health care providers, conducts or
9 arranges for utilization review activities, and contracts with a managed care entity;
10 (10) "managed care entity" means an insurer, a hospital or medical
11 service corporation, a health maintenance organization, an employer or employee
12 health care organization, a managed care contractor that operates a group managed care
13 plan, or a person who has a financial interest in health care services provided to an
14 individual;
15 (11) "medical emergency" means the sudden onset of a medical
16 condition that manifests itself by symptoms of sufficient severity, including severe pain
17 that in the absence of immediate medical attention would reasonably be expected by
18 a prudent person who possesses an average knowledge of health and medicine to result
19 in
20 (A) the placing of the person's health in serious jeopardy;
21 (B) a serious impairment to bodily functions; or
22 (C) a serious dysfunction of any bodily organ or part;
23 (12) "participating health care provider" means a health care provider
24 who has entered into an agreement with a managed care entity to provide services or
25 supplies to a patient covered by a group managed care plan;
26 (13) "primary care provider" means a health care provider who provides
27 general health care services and does not specialize in treating a single injury, illness,
28 or condition or who provides obstetrical, gynecological, or pediatric health care
29 services;
30 (14) "provider" means a health care provider;
31 (15) "religious nonmedical provider" means a person who does not

provide medical care, but who provides only religious nonmedical treatment or nursing care for an illness or injury;

(16) "utilization review" means a system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a group managed care plan using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review;

~~(17) "working day" means a day of the week that is not a Saturday,~~ Sunday, or a holiday.

* **Sec. 3.** AS 21.36.125 is amended by adding a new paragraph to read:

(16) violate a provision contained in AS 21.07.

* **Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

INDIRECT COURT RULE AMENDMENT. AS 21.07.050(g), as enacted by sec. 2 of this Act, has the effect of amending Rule 602(b), Alaska Rules of Appellate Procedure, by providing that an appeal from a decision of an external appeal agency must be filed within six months of the decision of the external appeal agency.

* **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CONDITIONAL EFFECT. AS 21.07.050(g), as enacted by sec. 2 of this Act, takes effect only if sec. 4 of this Act receives the two-thirds majority vote of each house required by art. IV, sec. 15, Constitution of the State of Alaska.

* **Sec. 6.** This Act takes effect July 1, 2001.

FAX TRANSMISSION COVER SHEET

Office of
Representative Pete Kott

ALASKA STATE LEGISLATURE

UD	
TO	number of pages, including cover
	269-0229
ORGANIZATION	FAX
House Judiciary	3/31/00
FROM	DATE

INTERNET: http://www.akrepublicans.org/Kott.htm
E-MAIL: Representative_Pete _Kott@Legis.state.ak.us

MESSAGE:

Notice of Confidentiality: This transmission is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged and confidential. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, distribution or copying of this information is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone, and thereafter destroy the transmitted copy. Thank you.

ALASKA STATE CAPITOL, ROOM 118 • JUNEAU, ALASKA 99801-1182
☎ (907)465-3777/(800)342-2199 • FAX: (907)465-4587

BRADY & COMPANY
INCORPORATED

Brady Building
1031 W. 4th Avenue, Suite 400
P.O. Box 107502 • Anchorage, AK 99510-7502

April 3, 2000

To: Representative Rokeberg, Chair, House Labor & Commerce Committee
Representative Kott, Chair, House Judiciary Committee

Re: HB211

Dear Representatives Rokeberg and Kott,

In my role as health care consultant for a variety of large employers and health care Trusts, I have been following HB211 very closely, as it will have an unfavorable impact on my clients' health care plans. On March 31, 2000, the Judiciary Committee heard testimony on this bill. I was present in the Anchorage Legislative Office and was prepared to testify as to the impact this bill will have on health care plan sponsors. After starting a half-hour late, the hearing was abruptly terminated at approximately 2:35 pm before all testimony was taken. The Committee had received input from the medical fraternity and the insurance companies. The concerns of the plan sponsors – the entities that actually pay health care costs – went unheard. Needless to say, I was extremely upset. It seems you are more concerned about physicians and insurance companies than those Alaskans who actually pay the cost of health care, the plan sponsors.

Therefore, I am writing to you today to express my concerns regarding HB211 as it is written (Version N). In general, we support a patient's bill of rights and appreciate the changes that have been incorporated into the bill so far. However, we still have more work to do, as this legislation will needlessly increase plan costs as well as increase the administrative burden for operating plans. In addition, it creates significant conflicts with the Employee Retirement Income Security Act of 1974 (ERISA).

First, in order to mitigate conflicts with ERISA, we suggest the following language be incorporated into the Act:

> In no event will this Act infringe upon, be in conflict with, or supercede the provisions of the Employee Retirement Income Security Act of 1974 (ERISA), including amendments hereto and associated regulations.

Second we are concerned that the external appeals process will impose substantial administrative burdens on plan sponsors and participants. The process has the potential to require <u>three</u> claim appeal steps before proceeding to either court or arbitration. This is unacceptable for the average layman because of costs and time. We agree that an original internal appeal is necessary to determine if any errors had occurred. We suggest that after the initial internal appeal, participants should be allowed to appeal to the external review entity <u>and</u> the plan sponsor's fiduciaries jointly. The decision reached in this appeal should be based on plan provisions

Telephone: 907/276-5617 • Fax: 907/276-6292 or 907/276-6304

(including exclusions, limitations and definitions of medical necessity) contained in the plan document. In this way, only two appeals are required in total.

In addition, we can only support this bill if it allows plan sponsors to state their definition of medical necessity in the health plan's plan document. Medical necessity should not be defined in the Act. In no event should a plan sponsor be required to pay benefits that are considered medically necessary according to the attending physician, if those benefits are excluded by the plan. A statutory definition of medical necessity is driven by the physicians' desire to extend coverage for patients so that all procedures can be reimbursed without at least very limited cost control mechanisms in place via exclusions and limitations. Physicians should not be allowed to dictate to plan sponsors what is or is not covered under the plan. Plans must be allowed to define "medical necessity" and list excluded services.

Mr. Jordan, of the Alaska Medical Association, testified that the managed care entities "make medical decisions." They do not. Managed care entities determine whether or not coverage is available under a plan according to the plan documents. It is the participant's decision whether or not to proceed with treatment, regardless of plan coverage.

After listening to the testimony Friday, it seems the AMA and Alaska Physicians and Surgeons wish to make certain coverage is granted regardless of the plan sponsors' intent in drafting plan design. If the most liberal of all approaches is taken, and no restrictions are placed upon coverage by defining medical necessity and placing exclusions upon the plan, plan sponsors will not be able to afford benefit plans in their current configuration. As it currently exists, this bill will increase the cost of health care plans, therefore depleting the funds available to pay benefits. This means the plan sponsor will have to pay more into the plan to fund the current benefits, or reduce benefits for all procedures accordingly. Worse yet, plan sponsors, who are just barely able to afford a health care plan in our already expensive state, may have to cancel it because they can't afford what physicians demand.

We find it interesting that Mr. Jordan further stated the estimates of cost increases for similar legislation were "not that high." If a health plan is required to cover procedures currently excluded or limited by the plan, health care costs will certainly increase. Furthermore, if a plan is required to pay for additional administrative appeals, administration expenses will increase as well.

This bill is intended to benefit physicians at the expense of benefit plan sponsors. Moreover, the name, "Patient's Bill of Rights" is misleading, because this bill is not intended to benefit plan participants. When asked, a member of Representative Rokeberg's staff indicated this bill was not crafted in response to constituent complaints about managed care. Rather, this bill originated from Alaska physician requests.

Lastly, legislation defines a "managed care entity" as "an insurer, a hospital or medical service corporation, a health maintenance organization, an employer or employee health care organization, a managed care contractor that operates a group managed care plan, or a person who has a financial interest in health care services provided to an individual." The definition of "an employer or employee health care organization" is totally unclear. What does it mean?

In general, this bill appears as though it is intended to mirror the Patient's Bill of Rights in Washington, D.C., which is currently under debate. The federal legislation has not yet passed and will probably still be amended. HB211 could easily end up in conflict with the final version of the federal bill, which means the Alaska legislature will have spent a significant amount of fruitless time and effort. If the intent is not to infringe upon ERISA and to mirror federal legislation, we strongly encourage defeat of this state legislation or deferral to the next legislative session to accurately assess the final version of the federal Patient's Bill of Rights.

As representatives of the State, we encourage you to contact those parties who are responsible for the payment of health care costs – the plan sponsors – to help build this legislation rather than to simply impose unworkable restrictions that will increase revenue to physicians, and by doing so, increase Alaska's high health care costs even further.

Sincerely,

Ed Burgan
Senior Vice President

cc: Associated General Contractors of Alaska
Mechanical Contractors of Anchorage
Mechanical Contractors of Fairbanks
Steel Erectors Associations
Northern Electrical Contractors
Alaska Hotel and Motel Association
Members of the Labor and Commerce and Judiciary Committees
Alaska State AFL-CIO
All Labor Organizations Sponsoring Health & Welfare Plans
Anchorage Chamber of Commerce
Brady & Company Clients
Health Care Cost Management Corporation of Alaska

Insurance Co don't want medical necessity language in. b/c ① cosmetic surgury area
② experimental surgury

- WA state excluded medical necessity but included a version of liability. (Get copy from Sam)

- get a copy of insurance company contracts
- like bill

Jim Jorden: AK St Med Assoc → The 2 areas of medical necessity + Liability area

→ Has a problem w/ language in version "N" not only w/ 2 concepts being eliminated

House: HR 2990 → allows external agency to go outside contract definitin of medical necessity.

So, @ the very least external agency review.

→ will send written analysis

---

* definition of medical necessity is problematic for ins. co b/c gives Drs sole discretion & they economic / & non-economic factors

INS. COS think that pg 9 sec(8) gives enough extra protection beyond policy allowing for med necessity.

There needs to be a balance b/w DRS. free reigne c̄ ins. cos.

- Concerns Re:
  Jorden c̄ Hogan

pardon me for interupting you, while I am speaking.

is not contrary to the terms of coverage under the covered person's health benefit plan;

(A) consistent with the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations; and

NAIC external review model act

(6) Any applicable clinical review criteria developed and used by the health carrier or its designee.

(7) If adverse determination or final adverse determination involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, whether:

S. Carolina language

(a) The recommended or requested health care service or treatment has been approved by the federal Food and Drug Administration; or

(b) Medical and scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or treatment would be greater than the benefits of any available standard service or treatment and the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of standard services or treatments.

(1) Within forty-five (45) days after the date of receipt of the request for an external review by the health carrier, the independent review organization shall provide written notice of its decision to uphold or reverse the adverse determination or the final adverse determination to:

(a) The covered person or his authorized representative; and

(b) The health carrier;

(2) The independent review organization shall make a decision to uphold or reverse the health carrier's adverse determination or final adverse determination based upon the recommendation of a majority of the clinical peer review panel.

RECEIVED
APR 06 2000

BRADY & COMPANY
INCORPORATED

Brady Building
1031 W. 4th Avenue, Suite 400
P.O. Box 107502 • Anchorage, AK 99510-7502

6 April, 2000

To: Representative Rokeberg, Chair, House Labor & Commerce Committee
Representative Kott, Chair, House Judiciary Committee

Re: HB211, Version S

Dear Representatives Rokeberg and Kott,

On April 3, 2000, we faxed you a letter expressing our concerns about Version N of HB211. In that letter, we encouraged you to consider the needs of health care plan sponsors (those Alaskans who pay the cost of health care), and offered a number of recommendations on their behalf.

This morning, we received a copy of HB211, Version S. Upon first review, it seems that 100% of our recommendations were ignored. Therefore, the comments expressed in our April 3rd letter remain unchanged.

When we received Version S, we also learned a Judiciary Committee hearing is scheduled this afternoon at 2:00pm to discuss this bill. It is troubling that the Committee did not allow sufficient time between release of the work draft and the scheduled hearing so that involved parties (other than physicians) have sufficient time to review the changes and provide input. Some people may consider the short time frame your strategy to ignore constituent input. We wouldn't call it that, but we believe it is in the best interest of Alaskans to allow your constituents a few days to review amended legislation and provide comment in the future.

We contacted the following organizations to notify them of the changes made in Version S. They requested us to convey their continued opposition to HB211.

Associated General Contractors of Alaska
Alaska Steel Contractors and Erectors Association
National Electrical Contractors Association
Alaska State AFL-CIO
Alaska Teamsters Welfare Trust
Alaska UFCW Health & Welfare Trust
Health Care Cost Management Corporation of Alaska

We are also confident of similar support from other organizations, but due to the time constraints imposed by your 2:00 Committee Meeting, we have not been able to contact them.

Telephone: 907/276-5617 • Fax: 907/276-6292 or 907/276-6304

It is likely that the above-named organizations' members and families represent 20-25% of the population of the State of Alaska. We find it interesting that this legislation is opposed by the above-named organizations and the participants they represent, but the Committee continues to follow the lead of the physicians' groups in pushing for its passage. We encourage you to consider the needs of plan sponsors and participants, as well as the desires of physicians, when you meet this afternoon.

As we stated in our letter of April 3rd, we support the concept of a patient's bill of rights and would agree to help draft such legislation. We do not believe HB211 provides any additional patient protection not currently provided under state of federal law. Rather, we believe HB211 protects the physician community, and patients and plan sponsors would be adversely affected by passage of this bill.

Sincerely,

Ed Burgan
Senior Vice President

cc: All organizations listed above
All Brady & Company clients
Governor Tony Knowles

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

INTERIM:
716 WEST 4TH AVENUE, SUITE 640
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

SESSION:
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

MEMORANDUM

TO: Rep. Pete Kott, Chairman
House Judiciary Committee

FROM: Rep. Norman Rokeberg

DATE: March 20, 2000

RE: CSHB 211 (L&C)

Thank you for scheduling HB 211 for hearing before the House Judiciary Committee on Friday, March 24th.

Attached are the following:

1. CSHB 211 (L&C)
2. Sponsor Statement
3. Sectional Analysis
4. Zero fiscal note
5. Legislative Legal Counsel Memorandum dated Feb. 10, 2000, regarding emergency room services
6. Proposed amendment regarding confidentiality language (page 9)
7. Attorney General's Memorandum Opinions Concerning PPOs
8. February 24, 2000, letter from Alaska State Medical Association and "Economic Impacts of Managed Care Reform" study.
9. List of support letters received on HB 211
10. Brunner, Jim, "So far, Texans happy with patient-rights law", Seattle Times, March 12, 2000
11. Washington Office of the Governor, "Locke signs 'Patient's Bill of Rights' legislation", March 15, 2000
12. "Managed Care: Where Do We Go From Here", March 1999 State Legislatures.

I would request that this meeting be teleconferenced to Anchorage as well as other LIO locations that may care to be a part of any hearing.

ALASKA STATE LEGISLATURE

House of Representatives

Committee Assignments:

Labor & Commerce Committee, Chairman
Judiciary Committee, Member
Legislative Council, Member
Special Committees:
Utility Restructuring, Member
Economic Development, Member
Budget Subcommittees:
Commerce & Economic Development, Member
Corrections, Member
Labor, Member

Interim:
716 West 4th Avenue, Suite 640
Anchorage, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

SESSION:
State Capitol
Juneau, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2840

REPRESENTATIVE NORMAN ROKEBERG

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

SPONSOR STATEMENT
HB207

"An Act relating to home inspections."

HB207 will protect consumers and the home inspection industry by prohibiting certain home inspector trade practices and limiting legal actions against home inspectors. HB207 revises Title 9, Civil Actions, by limiting them; it is not a home inspector licensing bill.

Consumers deserve assurance that they can bring an action against an individual home inspector based on the contents of or omissions in a written home inspection report. HB 207 allows recourse against inspectors; it is limited to the person who contracted and paid for the report and the action must be brought within one year of the written report. HB207 further accomplishes this by making it contrary to public policy and void for any home inspection report limiting liability to the cost of the report.

A faulty inspection could have serious consequences for consumers, particularly when they are buying or selling a home. Common sense dictates that home inspectors must be held accountable for their work.

I have met with representatives from the industry who agree that home inspector accountability is a worthy goal. The goal of HB 207 is to establish a framework, within which the home inspector can operate, the home inspection profession is protected and consumers are shielded from egregious faulty inspections.

I urge you to support this legislation.

03/16/00 HB207(L&C) version T

Alaska State Legislature
HOUSE OF REPRESENTATIVES

Official Business

State Capitol
Juneau, AK 99801-1182

SUBJECT: SECTIONAL ANALYSIS: HB 207/(L&C)

HOUSE BILL 207: "A BILL RELATING TO HOME INSPECTIONS"

FROM: Representative Norman Rokeberg

DATE: March 16, 2000

SECTION 1.
Limits the legal actions against a home inspector to action brought by the person who contracted and paid for the written home inspection report; and is limited to within one year after the date of the written report. It makes any contract provision limiting the liability of a home inspector to the cost of the home inspection report as contrary to public policy and void. It defines applicable home inspection, real estate transaction and residence.

SECTION 2.
Delineates prohibited acts relating to home inspectors, including, prohibiting:
getting an extra fee to perform repairs on any structure that the individual or the company has prepared a home inspection report in the past 12 months;
inspecting for a fee any property that they have a financial interest;
offering or delivering compensation for referral of business;
disclosing information from a home inspection report, without written consent from the home inspection client or the client's representative or within one year after the date of the report , unless to a subsequent client who requests a home inspection of the same premises;
accepting compensation from more than one interested party for the same services without the written consent of all interested parties;
accepting a commission or allowance, directly or indirectly, for work for which the individual or company is responsible;
accepting a fee payable or contingent fee for a report, based on the conclusions, preestablished findings, or the close of escrow.

It defines home inspection, intentionally, real estate transaction and residence. It makes violation of this section a class A misdemeanor.

tjm/03/16/2000HB 207(L&C)sectional analysis)

FISCAL NOTE

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. CSHB 211

Revision Date/Time (Note if correction) 03/06/00
Title: An Act relating to liability for providing managed care services, to regulation of managed care insurance plans . . .
Sponsor: Rokeberg
Requester: (H) L&C

Dept. Affected: Community & Economic Development
BRU: Insurance
Component: Insurance
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Sec. 21.07.020, page 7, lines 8-11 require that a managed care entity provide actuarial support to the director upon request for the increased cost of using a non-network provider. It is estimated that fewer than 15 insurers have provider network provisions in their health insurance contracts. Therefore, it is anticipated that no additional resources will be needed to request and review the increased costs of non-network provider use.

Sec. 21.07.060, page13, line 17, requires that the director approve "qualified private standard-setting organizations". It is estimated that there are currently fewer than 5 of these organizations. Therefore, it is anticipated that no additional resources will be needed for the director to certify these "qualified private standard-setting organizations". Also, it is anticipated that no additional resource will be needed to develop regulations, should they be needed, to define related party as provided on page 14, lines 20-22 of this section.

Prepared by: Robert A. Lohr
Phone: 269-7900
Division: Insurance
Date/Time: 3-7-00 9:28 AM
Approved by Commissioner Deborah B. Sedwick
Date: 3-7-00
Agency: Community & Economic Development

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE
For further distribution information, call the Governor's Legislative Office

(Rev 10/99) 2000fnform.xls/OMB

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 10, 2000

SUBJECT: Managed care - (CSHB 211(L&C))

TO: Representative Norman Rokeberg
Attn: Janet

FROM: Michael F. Ford
Legislative Counsel

You asked two questions regarding CSHB 211(L&C). First you asked if the last sentence in sec. 21.07.030(a) covers a situation when the insured has other insurance that provides non-network coverage. The answer is yes. Second, you asked if there is a conflict between a managed care plan and a statute, which prevails. While the legislature cannot change the terms of an existing managed care plan, the legislature can dictate the terms of a managed care plan entered into or renewed after the law takes effect. So if there is a conflict between the provisions of a managed care plan and statute, the statute prevails unless the contract was in existence prior to the law taking effect. See AS 21.42.265.

Please contact me if you have further questions.

MFF:pl:glc
00-048.plm

AMENDMENT #____

OFFERED IN THE HOUSE BY REP. ROKEBERG

TO CSHB 211 (L&C)

Page 9, lines 5-10: DELETE

Page 9, line 4: After "public disclosure." INSERT following:

(b) Nothing in this section shall be construed to apply to the release of medical information for:

(1) Research using medical information that is subject to federal laws and regulations protecting the rights and welfare of research participants; or
(2) Research using anonymized health information in which the confidentiality of participants is protected by coding or encryption of information that reveals the identity of the patient.

Memorandum Opinion 95-0654

LEGALITY OF PREFERRED PROVIDER ORGANIZATIONS IN ALASKA

April 21, 1995

I. INTRODUCTION

This is in response to your memorandum dated April 13, 1995, by which you requested an opinion on the following question: "Are Preferred Provider Organizations (PPOs) legal in Alaska?" Our conclusion is that they are lawful, although there is no enabling legislation for

II. BACKGROUND

PPOs are a relatively recent development in the health care delivery arena. For much of this century, traditional indemnity insurance, whether through individual or group insurance policies, provided the primary means for health care reimbursement. In the last few decades, due in large part to the trend of disproportionately large increases in health care costs, alternatives to pure indemnity insurance evolved. Many of these alternatives fall under the rubric of managed care and have a primary purpose of cost containment. For instance, in the 1970s, statutory enabling laws for health maintenance organizations (HMOs) were created.[1] Alaska enacted its version of the HMO model law (AS 21.86) in 1990. However, to date there are no licensed HMOs in Alaska.

In the 1980s, PPOs developed as a managed care device.[2] PPOs are a fee-for-service alternative to traditional health insurance. Due to their dramatic growth they soon became a central feature of health care financing and delivery reform.

The PPO, also referred to as a preferred provider arrangement (PPA),[3] involves purchasers managing the cost of health care through contracting with a group of doctors or hospitals ("preferred" or "network" providers). The salient characteristics of the preferred provider arrangement are as follows. In exchange for discounted fees for services, the providers receive a guaranteed supply of patients and a commitment to quick turnaround on claims payments. Providers also typically agree to comply with utilization review procedures intended to reduce inappropriate or unnecessary care. Through a bulk purchase of medical services, purchasers have the advantage of being able to choose providers based on competitive pricing, which is expected to result in

© 1999, NILS Publishing Company
8/99

cost savings. Patients are offered financial incentives such as reduced or eliminated copayments or deductibles if they use designated preferred providers. PPOs are formed by a wide variety of entities — purchasers as well as providers — including insurers, self insurers (employers), unions, physicians, hospitals, HMOs, service corporations, and third party administrators (often owned by insurers).[4]

At a recent hearing before the Senate Labor and Commerce Committee, a representative of the Division of Insurance was asked whether preferred provider organizations (PPOs) are legal in Alaska. The division's response that PPOs are not lawful has created some controversy. The largest group disability[5] insurer in the state (Aetna Life Insurance Co.) has been utilizing PPOs for years based in part on the division's approval of its insurance forms. The Division of Retirement and Benefits also has expressed concern regarding the use of PPOs in the state health plan. As a result, you have referred this question to the Department of Law for a legal opinion.

III. ANALYSIS

PPOs are lawful in Alaska. While there is no enabling legislation for PPOs, no provision of AS 21 on its face prohibits the formation of PPOs or contracting with such entities.

By way of background, and as previously indicated in this memorandum, there is a model law developed by the National Association of Insurance Commissioners (NAIC) entitled the "Preferred Provider Arrangements Act." Currently, over half of the states (29) have adopted some version of the PPO model by legislation, regulation, or bulletin.[6] Alaska has not adopted a version of the model. Whether or not it should have is beyond the scope of this opinion.

It is noteworthy that states have been criticized for passing laws that impede the implementation of PPOs. Even before the creation of the model act, legislation was introduced in Congress in 1983 to prohibit states from restricting the operations of the already emerging PPO mechanism.[7] The existence of PPOs in the absence of enabling legislation is also evidenced by a drafting note for Section 2 of the model (Purpose), which states: "The use of the term 'allowing' in this section is not intended to indicate that health care insurers are acting unlawfully in a state which has not enacted a law allowing Preferred Provider Arrangements."[8]

Although federal law recognizes the PPO mechanism, it does not

© 1999, NILS Publishing Company
8/99

answer the question whether PPOs are legal in Alaska. In a regulation implementing the Medicare program, the Department of Health and Human Services refers to health plans having "premium structure regulated under a State insurance statute or a State enabling statute governing health maintenance organizations or preferred provider organizations." 42 C.F.R. § 1001.952(1)(2). This regulation does not mandate the use of an enabling law for PPOs. The CHAMPUS program, which expressly authorizes federal officials to contract with PPOs, also does not require a state enabling statute. *See* 10 U.S.C. § 1095.

There are no published cases, state or federal, addressing whether PPOs are lawful in the absence of enabling legislation. One case implicitly acknowledges the validity of a state PPO enabling law. In *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993), the court held that ERISA's savings clause exempted from federal preemption a Virginia enabling law for establishing PPOs. However, there is no federal mandate for an enabling law. Each state may regulate PPOs as it sees fit, in the absence of congressional direction.[9]

Recognizing that there is no Alaska enabling law for PPOs, the Division of Insurance has previously taken the position that certain provisions of the insurance code prohibit the use of PPOs. We find this argument unpersuasive for the following reasons.

AS 21.54.020(a)

One of the provisions the division relies upon is a prohibition applicable to group disability insurers that provides in part: "The [group disability] policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86." AS 21.54.020(a). This law does not prohibit the use of a PPO. To begin with, HMOs, which may contract with a PPO, are exempted. *See id.*; AS 21.86.060(a). In addition, the typical health plan utilizing a PPO gives covered individuals the choice of more than one provider, and often there is an option to use a nonpreferred provider, albeit at higher cost. Only if the covered person is given no choice of provider would this provision be violated.

AS 21.36.090(b)

Another statute relied upon by the division as prohibiting PPOs is AS 21.36.090(b). It provides:

> A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same

© 1999, NILS Publishing Company
8/99

> hazard in the amount of premium, policy fees, or rates charged for a policy or contract of disability insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

This provision prohibits only disability (health) insurers from unfairly discriminating against covered individuals. It is part of the Unfair Trade Practices Act (UTPA) in Alaska's insurance code, enacted in 1966 and based upon an NAIC model. Although the legislative history for AS 21.36.090(b) is scant and has no bearing on the PPO issue, the model act is instructive. It was adopted in 1947, well before the emergence of PPOs and the managed care concept.[10] The unfair discrimination provision at AS 21.36.090(b) is substantially the same as the corresponding provision of the model act [Section 4(G)(2)]. The legislative history for Section 4(G)(2) reveals that the primary concerns about unfair discrimination were in the contexts of race, sex, marital status, residence and national origin. More recently, redlining and blackballing underwriting practices have received attention. There is no discussion of PPOs in the legislative history of the model. Indeed, it would be illogical for the NAIC to adopt a PPO model act if PPOs were per se violative of the UTPA. It is true that a PPO could violate AS 21.36.090(b) if its conduct were unfairly discriminatory for any one of a variety of reasons. However, it is additionally possible that there would be no "unfair" discrimination if a PPO treated all individuals of the same class equally as to costs, benefits payable or other contractual terms. In conclusion, AS 21.36.090(b) does not prohibit the establishment of PPOs or contracting with them.

Hospital and Medical Service Corporation (AS 21.87)

Your memorandum also addresses hospital and medical service corporations. *E.g.*, Blue Cross. These entities differ significantly from disability (health) insurers and are not even considered insurers. Unlike traditional insurance companies, which are subject to the provisions of AS 21.09, service corporations are regulated by the provisions of AS 21.87. Service corporations are nonprofit, at least in theory, and pursuant to statute. *See* AS 21.87.070(2). In essence, a service corporation delivers health care coverage through the use of two contracts. In the first one, a service agreement, the service corporation and a participant provider (typically a hospital or physician) agree to exchange health care services for a set fee. *See* AS 21.87.140 — 21.87.150. The second

© 1999, NILS Publishing Company
8/99

contract, called a subscriber contract, is between the service corporation and a recipient of care. *See* AS 21.87 160. It gives the subscriber access to health care services provided by the service contract.

Hospital and medical service corporations have statutory authority to contract with PPOs. *See, e.g.*, AS 21.87.070(3), 21.87.150 (service agreements with participant hospitals authorized); AS 21.87.070(4), 21.87.140 (service agreements with participant providers authorized); AS 21.87.120(a)(2), 21.87.130(a)(2), 21.87.160(b)(1), (2) (indemnity for services by nonparticipant providers and hospitals allowed). These statutes were enacted in 1966, well before the emergence of PPOs. They effectively allow a different benefit to be provided to a subscriber by a participant hospital or participant provider than benefits the subscriber may access on an indemnity basis. Although none of the statutes explicitly reference PPOs, their language is broad enough to allow contracting with PPOs.

Exclusive Provider Arrangements

Finally, your memorandum addresses "exclusive provider arrangements," also referred to as "exclusive provider organizations" or EPOs. These entities are a subspecies of PPOs. As previously indicated, for group disability (health) insurance, AS 21.54.020(a) prohibits the use of an EPO where the covered individual has no choice of provider. Depending on the circumstances, an EPO may also violate provisions of AS 21.36.

IV. CONCLUSION

Unlike most states, Alaska does not have an enabling law for establishing and using PPOs. For the reasons indicated in this memorandum, the Alaska insurance code nonetheless does not prohibit the creation of PPOs.

David G. Stebing
ASSISTANT ATTORNEY GENERAL

NOTES

[1] *See generally* 42 U.S.C. § 300e *et seq.* (Federal Health Maintenance Organization Act of 1973); Health Maintenance Organization Model Act, Vol. II, NAIC Model Laws, Regulations and Guidelines, pp. 430-1 through 430-31 (adopted 1973).

[2] *See* Gabel, Ermann, Rice & de Lissovoy, *The Emergence and Future of PPOs*, Vol. 11, Journal of Health Politics, Policy and Law, 305 (1986); Preferred Provider Arrangements

© 1999, NILS Publishing Company
8/99

Act, Vol. I, NAIC Model Laws, Regulations and Guidelines, pp. 75-1 through 75-4, (adopted 1987).

[3] A PPO is the group of providers whereas a PPA is the contractual arrangement between that group of providers and purchasers of health care. Your April 13, 1995, memorandum refers to PPOs. For the purpose of this opinion, the PPO and PPA mechanisms are interchangeable.

[4] There are myriad forms of PPOs whose description is beyond the scope of this opinion. *See generally* Combe & Krugman, *Design and Pricing of the PPO and EPO Products*, Practicing Law Institute, Commercial Law and Practice Course Handbook Series, September 25, 1986.

[5] Alaska is in the clear minority of states that uses the term "disability insurance" to refer to what is commonly known as "health insurance." *See* AS 21.12.050 (disability insurance defined); AS 21.54.060 (group disability insurance defined). "Disability insurance" includes "disability income replacement insurance."

[6] *See* Vol. I, *NAIC Model Laws, Regulations and Guidelines*, pp. 75-5 through 75-8 (1993).

[7] *See* Rolph, Ginsburg & Hosek, *The Regulation of Preferred Provider Arrangements*, 6 Health Affairs, 32, 33 (Fall 1987).

[8] *See id.* p. 75-1. *See also* Statement of Commissioner Grode (Pa.), Report of Working Group on Preferred Providers, Vol. 1, NAIC Proceedings, at 712 (1987) ("drafting note was added to clarify the possible ambiguity").

[9] *See generally* 15 U.S.C. §§ 1011-12 (McCarran-Ferguson Act delegation of insurance regulatory authority to states).

[10] *See* Vol. IV, *Model Laws, Regulations and Guidelines*, pp. 880-1 through 880-13 (1993). The NAIC's unfair trade practices model act was one of the initial efforts at developing uniform state legislation in response to the newly enacted McCarran-Ferguson Act. *See* NAIC Proceedings, at 142-43 (1946).

© 1999, NILS Publishing Company
8/99

Memorandum Opinion 96-0291

OPINION ON CHOICE AND PAYMENT OF PROVIDERS UNDER SERVICE CORPORATION BENEFITS

November 3, 1995

I. INTRODUCTION

This is in response to your memorandum dated October 9, 1995,[1] through which you requested answers to the following two questions:

1. Whether patients have the right to receive care from a provider of their choice?

Answer: Yes.

2. Whether providers are entitled to the same fees as those received by providers who enter into contracts with a medical service corporation?

Answer: No.

II. BACKGROUND

The above questions derive from inquiries made to the Alaska Division of Insurance by the Alaska Dental Society (ADS). The attachment accompanying your memorandum indicates ADS' position that the answer to both questions is "yes." Although ADS' inquiries are made in the context of dental care, my analysis and conclusions are applicable to dentists, medical doctors, and all other properly licensed health care providers[2] rendering services within the scope of their occupational licenses. In addition, my analysis for the first question addresses traditional health insurance as well as service corporations, although a primary emphasis is placed on the latter consistent with ADS' letter to you.

It is initially useful to understand the nature of a service corporation. A significant share of group health benefits in this country are provided through "service corporations." These health care financing entities are not traditional fee-for-service insurers, who typically provide for health care through indemnifying an insured after expenses are incurred. In contrast, a service corporation generally facilitates delivery of health care through periodic *pre*payments made by subscribers (recipients of

© 1999, NILS Publishing Company
8/99

care). *See* AS 21.87.010(a). A service corporation may, however, additionally provide subscribers with indemnity benefits. *See id.* AS 21.87.160(b)(2); AS 21.87.190(c).

There are three types of service corporations: (1) a medical service corporation principally provides medical or surgical services to subscribers; (2) a hospital service corporation principally provides hospital services to subscribers; and (3) a medical and hospital service corporation provides a combination of these services to subscribers. *See* AS 21.87.070; AS 21.87.280; and AS 21.87.330(2), (3). For the purpose of this memorandum, the term "service corporation" refers to all three of these entities. In Alaska, there are two authorized service corporations — Blue Cross of Washington & Alaska and Alaska Vision Services, Inc.

Service corporations are characterized by their use of two types of contracts. In the first one, a "service agreement," the corporation and a participant health care provider[3] (typically a hospital or physician) agree to provide health care services for a set fee. *See* AS 21.87.140; AS 21.87.150. A "nonparticipant" provider or hospital, as referenced in AS 21.87, is one that has not entered into a service agreement with the corporation. *See id.* AS 21.87.120(a)(2); AS 21.87.130(a)(2). In the second type of contract, called a "subscriber contract," a subscriber agrees to pay a set amount in exchange for certain health care benefits provided under the service agreement. *See id.* AS 21.87.160; AS 21.87.190. Another important characteristic of service corporations is that, in contrast to insurance companies, service corporations must be organized and operated in good faith as nonprofit entities. *See id.* AS 21.87.020(a); AS 21.87.070(2); AS 21.87.050(a); and AS 21.87.070(2).

Blue Cross and Blue Shield organizations are typically operated as service corporations and are the most well known types of service corporation. Historically, Blue Cross, which pioneered the hospital insurance market nearly 70 years ago, provided for hospital care, and Blue Shield provided for physicians' services (surgical and medical expenses). In 1982 the Blue Cross Association and the National Association of Blue Shield plans merged. The resulting national BlueCross BlueShield Association is currently comprised of 69 separate and locally operated companies called "plans." Blue Cross of Washington & Alaska, an affiliate of a larger holding company, is a member of the association. In the United States, more than 80 percent of hospitals and nearly 70 percent of physicians contract directly with Blue Cross and Blue Shield plans. Together, "Blues" plans in 1994 provided health care benefits for 7.6 million members, ultimately covering over 65 million people —

© 1999, NILS Publishing Company
8/99

roughly one in four Americans. *See BlueCross BlueShield Association 1994 Fact Book*; L. Kertesz, "A blue streak for managed care," *Modern Healthcare*, p. 63 (September 12, 1994). In Alaska, the Blue Cross plan has a large market presence, insuring about 95,000 Alaskans under group and individual policies (subscriber contracts).

There is often confusion about how to categorize a service corporation. The confusion is created in part by the fact that although a service corporation is not a traditional insurer, it is regulated by the state insurance regulatory agency. In Alaska, a traditional indemnity insurer is subject to the provisions of AS 21.09 concerning its authorization and general financial and reporting requirements. In contrast, a service corporation is primarily regulated by provisions of AS 21.87. Regulatory oversight of a service corporation remains similar in many ways to oversight of a traditional insurer by the division of insurance. *See e.g.*, AS 21.87.180 (contract language must be filed with and approved by division); AS 21.87.190 (rates must be filed with division and may not be excessive or unfairly discriminatory); AS 21.87.200 (requirements for adequate reserves); AS 21.87.210 (requirements for surplus fund); AS 21.87.220 (investment requirements); AS 21.87.230 (requirements for books and accounts); AS 21.87.240 (annual statement and fees requirements); AS 12.87.250 (periodic statutory examination); and AS 21.87.260 (taxation). In addition, AS 21.87.340 makes a service corporation subject to numerous other provisions of the insurance code, including most provisions of AS 21.09, so long as the provisions do not conflict with AS 21.87. A service corporation nonetheless is exempted from some important regulatory provisions applicable to traditional insurers. *See, e.g.*, AS 21.87.340 (exemption from Holding Company Act requirements of AS 21.22; and exemption from participation in guaranty association established by AS 21.79).

As further evidence of the confusion regarding how to categorize a service corporation, the entity is expressly prohibited from using a corporate business name including the word "insurance" or other terms descriptive of an insurer or insurer business. *See* AS 21.87.060. And, the U.S. Supreme Court has acknowledged in a case addressing what constitutes "the business of insurance" that Blue Cross as well as some members of Congress do not consider a service corporation's product to be insurance. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 228-29 (1979). Nevertheless, service corporations are commonly referred to as insurers and as engaged in the business of insurance. They are also often included within the rubric "group medical

© 1999, NILS Publishing Company
8/99

expense insurance." *See generally* D. Gregg, *Life and Health Insurance Handbook*, 427 (2d ed. 1964) (chapter entitled: "Group Medical Expense Insurance — Blue Cross and Blue Shield"). It is therefore not uncommon to see service corporations (*e.g.*, Blues) characterized as insurance in some contexts but not as insurance in others.

III. ANALYSIS

A. A patient has the right to receive health care services from the provider of her/his choice.

Your first question focuses on the right of a patient to choose a provider. In the broad context of traditional health insurance, the answer is that a patient (insured) has an unqualified right to seek health care services from the provider of her/his choice. The Alaska insurance code uses the term "disability insurance"[4] to refer to what is commonly known as health insurance. For individual disability insurance policies, the statutory requirement for payment of indemnity to a provider is qualified by the language: "this paragraph does not require that services be provided by a particular hospital or person." *See* AS 21.51.120. Similarly, under AS 21.54.020(a) a group disability policy "may not contain a provision requiring that services be provided by a particular hospital or person," except as applicable to an HMO. The Unfair Trade Practices Act for insurance (AS 21.36) provides additional support for a patient's freedom to choose a provider. AS 21.36.090(b) prohibits a person from unfairly discriminating in a policy or contract of disability insurance. An insurer limiting a patient's ultimate right to use the provider of her/his choice — regardless of provision for payment — violates this provision.

Provisions of AS 21.87, the chapter regulating service corporations, also acknowledge the freedom to choose. As previously addressed, in the typical situation the service corporation enters a contract with "participating" providers. *See* AS 21.87.120(a)(1) (medical and surgical services); AS 21.87.130(a)(1) (hospital services). However, this does not preclude a subscriber from obtaining services of a nonparticipating provider. AS 21.87 expressly authorizes a service corporation to provide indemnification for services provided by nonparticipant providers. *See id.* AS 21.87.120(a)(2) (indemnity for medical and surgical services); AS 21.87.130(a)(2) (indemnity for hospital services).

It is necessary to distinguish that although a service corporation has the right to offer coverage extending payment to a nonparticipant provider, the corporation is not obligated to provide for indemnity of a

© 1999, NILS Publishing Company
8/99

nonparticipant provider. The right to provide a subscriber "indemnity in a reasonable amount" (AS 21.87.120(a)(2) and AS 21.87.130(a)(2)) is not a mandate. The following provisions support this conclusion. AS 21.87.160(b)(2) requires that a subscriber contract must include "the benefits, *if any*, to which the subscriber is entitled on an indemnity basis. . ." (emphasis added). And, it is noteworthy that the minimum service benefits which must be provided through a subscriber contract apply only to participant providers and participant hospitals. *See id.* AS 21.87.170.

As further support of a subscriber's right to choose a provider, a PPO, which allows health care recipients a choice from among a group of providers, is not prohibited by the insurance code. *See generally* 1995 Op. Att'y Gen (Apr. 21; 661-95-0654). A service corporation may contract with a PPO as a participant provider. For service corporation subscribers, this means they can choose to receive health care from among providers who have entered a service agreement, presumably at a lower (negotiated) fee. However, even if a service corporation contracts with a PPO, its subscribers still have the option to use a nonparticipant provider outside the PPO. *See* AS 21.87.120(a)(2); AS 21.87.130(a)(2).

The Unfair Trade Practices Act provides further support for the conclusion that a subscriber may seek treatment from the provider she/he chooses. AS 21.36.090(d) prohibits unfair discrimination in the group context against a provider rendering health care under a service or indemnity type contract issued by a nonprofit corporation (*e.g.*, service corporation).[5] The prohibition applies whether the provider is a participant (having entered a service agreement) or nonparticipant.

And finally, AS 21.87.160(c) provides as follows:

> A [subscriber] contract may not restrict the subscriber's right to free choice of provider or hospital, but must restrict benefits to be provided on a service basis to services rendered by participant providers and participant hospitals.

This provision, which corresponds with AS 21.87.170, reflects that a subscriber has an unqualified right to choose a provider.

B. A nonparticipant provider is not entitled to the same fees as a participant provider in the absence of a contractual provision to the contrary.

While a subscriber has the freedom to use the health care provider of

© 1999, NILS Publishing Company
8/99

her/his choosing, *payment* for services rendered by a nonparticipant provider is subject to terms of the subscriber contract. The insurance code provides that indemnification of a nonparticipant provider must be in a "reasonable amount." *See* AS 21.87.120(a)(2) (medical and surgical services); AS 21.87.130(a)(2) (hospital services). And, as required by statute, the language used by a service corporation in a subscriber contract must be filed with and approved by the division of insurance. *See* AS 21.87.180. This filing requirement applies to contract language providing for indemnification when a subscriber uses a nonparticipant provider.[6] In practice, when the division receives a subscriber contract, it reviews the filing for compliance with applicable provisions of the insurance code, including those of AS 21.87.120(a)(2) and AS 21.87.130(a)(2) requiring that indemnity to nonparticipant providers must be "reasonable" in amount. These provisions do not require that the amount to be indemnified must be equal to the amount paid for a covered benefit under a service agreement. In light of these provisions, AS 21.87 leaves a service corporation discretion to pay a nonparticipant provider less than a participant provider for the same covered service. Payment of different amounts, depending on whether a provider is a participant or nonparticipant, is not *unfair* discrimination. *See* AS 21.36.090(d).

Please do not hesitate to contact me if you have any questions.

David G. Stebing
ASSISTANT ATTORNEY GENERAL

NOTES

[1] I received your memo on October 25, 1995.

[2] In the context of a service corporation, "provider" is defined as "a physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, or other licensed health care practitioner." AS 21.87.330(8).

[3] "Participant provider" and "participant hospital" mean a person (or hospital) that has entered into a service agreement with a service corporation. AS 21.87.330(5) and (6). These statutorily defined terms are not synonymous with the concept "preferred provider" as used in the context of a preferred provider organization (PPO).

[4] *See* AS 21.12.050. Disability insurance is not the same as disability income replacement insurance.

© 1999, NILS Publishing Company
8/99

[5] This provision does not apply to individual coverages.

[6] There is an exception from the filing requirement for certain contractual language (*e.g.*, endorsements, forms of unique character). *See* AS 21.87.180(a).

© 1999, NILS Publishing Company
8/99

§ 21.36.080 Boycott, coercion, and intimidation

A person may not enter into an agreement to commit, or by any concerted action commit, an act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

History.—§ 1, ch. 120, SLA 1966.

§ 21.36.090 Unfair discrimination

(a) A person may not make or permit unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for a contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of the contract.

(b) A person may not make or permit unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for a policy or contract of health insurance or in the benefits payable, or in any of the terms or conditions of the contract, or in any other manner whatever.

(c) A person may not make or permit arbitrary or unfair discrimination between insureds or property having like insuring or risk characteristics, in the premium or rates charged for a policy or contract of property, casualty, surety, marine, wet marine or transportation insurance, or in the dividends or other benefits payable on the insurance, or in the selection of it, or in any other terms and conditions of the insurance.

Text of subsection (d) effective until January 1, 1999

(d) Except to the extent necessary to comply with AS 21.42.365 and AS 21.56, a person may not practice or permit unfair discrimination against a person who provides a service covered under a group health insurance policy that extends coverage on an expense incurred basis, or under a group service or indemnity type contract issued by a health maintenance organization or a nonprofit corporation, if the service is within the scope of the provider's occupational license. In this subsection, "provider" means a state licensed physician, dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapist, occupational therapist, psychologist, psychological associate, or licensed clinical social worker, or certified direct-entry midwife.

© 1998, NILS Publishing Company
11/98

the employee or member and to whom benefits are payable; if dependents are included in the coverage, only one certificate need be issued for each family unit;

(3) a provision that to the group originally insured may be added from time to time eligible new employees or members or dependents, as the case may be, in accordance with the terms of the policy.

History.—§ 1, ch. 120, SLA 1966; § 68, ch. 56, SLA 1996, eff. 9-9-96.

§ 21.54.015 Rate discrimination prohibited

Rates charged for a group health insurance policy may not be excessive, inadequate, or unfairly discriminatory.

History.—§ 58, ch. 81, SLA 1997, eff. 7-1-97.

§ 21.54.020 Direct payment to health care provider

(a) An insurer may, and upon written request of the covered person shall, within 30 working days after receiving a proof of loss statement, pay indemnities under a group health insurance policy directly to the provider of the hospital, nursing, medical, dental, or surgical services. The policy may not contain a provision requiring that services be provided by a particular hospital or person, except as applicable to a health maintenance organization under AS 21.86. If the insurer pays indemnities to the covered person after the covered person has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the service, the insurer shall also pay those indemnities to the provider of the service.

(b) A covered person may revoke an election of direct payment of indemnities made under (a) of this section by giving written notice of the revocation to the insurer and to the provider of the services. The written notice of revocation given to the insurer must certify that the covered person has given written notice of revocation to the provider of the services. Revocation of an election of direct payment is not effective until the notice of revocation is received by the insurer and the provider of the services.

(c) The right of the covered person to request payment of indemnities under a blanket health insurance policy directly to the provider of the services or to another person may be transferred to a person who is not the covered person by a qualified domestic relations order. Rights under the qualified domestic relations order do not take effect until the

© 1998, NILS Publishing Company
2/98

period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof."

History.—§ 1, ch. 120, SLA 1966.

§ 21.51.120 Payment of claims

(a) A health insurance policy delivered or issued for delivery must contain the following provisions:

(1) indemnity for loss of life shall be paid according to the beneficiary designation and payment provisions contained in the policy that are effective at the time of payment; if a beneficiary has not been designated, indemnity shall be paid to the estate of the insured; accrued indemnities unpaid at the insured's death shall be paid to either the beneficiary or the estate, at the option of the insurer; all other indemnities shall be paid to the insured;

(2) the insurer may, and upon written request of the insured shall, within 30 working days after receiving a proof of loss statement, pay indemnities for hospital, nursing, medical, dental, or surgical services directly to the provider of the services; an insurer who pays indemnities to an insured, after the insured has given the insurer written notice in the proof of loss statement of an election of direct payment of indemnities to the provider of the services, shall also pay indemnities to the provider of the services; this paragraph does not require that services be provided by a particular hospital or person;

(3) a covered person may revoke an election of direct payment of indemnities made under this subsection by giving written notice of the revocation to the insurer and to the provider of the services; the written notice of revocation given to the insurer must certify that the covered person has given written notice of revocation to the provider of the services; revocation of an election of direct payment is not effective until the notice of revocation is received by the insurer and the provider of the services;

(4) the right of the insured to request payment of indemnities for hospital, nursing, medical, dental, or surgical services directly to the provider of the services or to another person may be transferred to a person who is not the insured by a qualified domestic relations order; rights under the qualified domestic relations order do not take effect until the order is received by the insurer; in this paragraph, "qualified

 © 1998, NILS Publishing Company
2/98

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 24, 2000

RECEIVED
FEB 28 2000

Honorable Norm Rokeberg
Chairman, House Labor and Commerce Committee
State of Alaska
House of Representatives
Room 24
Juneau, Alaska 99801-1182

RE: Your Request of an "Executive Summary"

Dear Representative Rokeberg:

At our meeting on 2/22/00 you requested that I provide you with an "executive summary" of the results of the various studies that have been done in regards to the estimated cost implications of the "patient bill of rights" legislation. Attached is a chart done by the AMA. It comes from a publication called "*Economic Impacts of Managed Care Reform*" written by David W. Emmons, PhD and Gregory D. Wozniak, PhD of the AMA's Center for Health Policy Research.

You had asked specifically about the cost of the mandatory point of service option. Please note the projected premium increases range form 0.1% to 0.48%. (The Barents study lists the impact in different terms. The impact is stated such that it would reduce the premium savings realized from a closed-panel option by from 4 to 11 percentage points).

Please let me know if you would like any additional information. (Finally, the Texas Medical Association staff has reported to me that the premium costs have not increased, following the enactment of the Texas Patient Bill of Rights, at any rate different than the rest of the country.)

Thank you for your support on Alaska's Patients Bill of Rights.

Sincerely,

James J. Jordan
Executive Director

cc: ASMA Board of Trustees

JJJ/kms

Freedom of Choice Acts	9%-16% (depending on plan type)					
Elimination of Prior Authorization for Specialty Referrals/Direct Access within Network	9%	0.0%-0.2%	0.2%			
Medical Necessity Determination	4.1%-6.1%[b]					
Continuity of Care		minimal increase				0.2%
Mandatory Point-of-Service Option	4%-11% (among closed panel plans)	0.3%	0.3%		0.48% (assumes plan members incur higher cost sharing out of network)	0.1%
Any Willing Provider		6.6%-8.6%[b]				
Equivalent Reimbursement Rates In and Out of Network		less than 0.5%	5.5%			
Provision of Emergency Room and Urgent Care Services with Limits on Prior Authorization	1%-3% (among managed care plans)	less than 0.05%	0.5%	less than 1%	0.11%	0.2%
Administrative Requirements			2.0%			
Elimination of Limits on Certain Benefits			5.5%			
Adverse Selection Against Rate Increases	0.1% to 0.5%	4.5%				
Access to Specialists and Standing Referrals to Specialists				0.35% choice of (OBGYNs as primary care providers)	0.02%	0.1%

Feb 28 00 01:19p Alaska St Med Assn 907 561 2063 p.5

Exhibit 10 (continued)
Summary Comparison of Managed Care Legislation Costs[a]

Proposals	Barents for AAHP	Muse & Associates for PARC Alliance	Milliman & Robertson for Walmart	Lewin for President's Commission	Price Waterhouse for Kaiser Family Foundation	Coopers & Lybrand for Kaiser Family Foundation	CBO	Mercer
Minimum Stays for Mastectomies					0.01% (48-hour stays)		less than 0.05%	
Expanding Drug Formularies					less than 0.6% (among HMOs)		less than 0.05%	
External Appeals				less than 0.05% (excludes administrative costs)		0.08% (includes administrative costs charged back to plans)	0.3%	
Information Reporting & Disclosure		0.3%-1.3%		0.3%-1.3%		.08%-.4% (under PARCA and CBRR, respectively)	0.3%	

Sources: Barents Group, LLC, *The Effects of Legislation Affecting Managed Care on Health Plan Costs*, (May 1997); Barents Group, LLC, *Impact of Legislation Affecting Managed Care Consumers: 1999- 2003*, (April 1998); Muse & Associates, *The Health Premium Impact of H. R. 1415/S.644, the Patient Access to Responsible Care Act (PARCA)*, (January 1998); Milliman & Robertson, Inc., *Actuarial Analysis of the Patient Access to Responsible Care Act (PARCA)*, (November 1997); The Lewin Group, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals*, (November 1997); Price Waterhouse, *The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals in California*, (November 1997); Coopers & Lybrand, LLP, *Estimated Costs of Selected Consumer Protection Proposals*, (April 1998); Congressional Budget Office, *Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Rights Act of 1998*, (July 1998); and William M. Mercer, Inc. and the American Medical Association, *Malpractice Liability Assessment Model: Estimates of the Cost Impact of Managed Care Accountability Legislation* (August 1998).

a/ Estimates of increased costs or reductions in savings rather than premium increases have been specified.
b/ Figures from Barents (1998), all other figures in the column are from Barents (1997).

American Medical Association

Physicians dedicated to the health of America

Economic Impacts of Managed Care Reform

Center for Health Policy Research

Economic Impacts of Managed Care Reform

David W. Emmons, PhD
Gregory D. Wozniak, PhD

©Copyright 1999
Center for Health Policy Research
American Medical Association

Contents

Page

List of Exhibits iv

Executive Summary v

Introduction 1

Reviews

Milliman & Robertson 3

Muse & Associates 7

Lewin Group 11

Price Waterhouse 15

Barents Group (1997) 19

Barents Group (1998) 23

Coopers & Lybrand 31

Congressional Budget Office 35

William M. Mercer 43

References 51

List of Exhibits

Exhibit **Page**

1 Milliman & Robertson:
Patient Access to Responsible Care Act 3

2 Muse & Associates:
Patient Access to Responsible Care Act 7

3 Lewin Group:
Information Disclosure 13

4 Lewin Group:
Midpoint Estimates for Information Disclosure 14

5 Barents (1997):
Percent Savings Relative to Traditional Indemnity 21

6 Barents (1998):
Percent Savings Relative to Traditional Indemnity 24

7 Coopers & Lybrand:
Consumer Bill of Rights & Responsibilities and
Patient Access to Responsible Care 31

8 Congressional Budget Office:
Patients' Bill of Rights Act of 1998 36

9 William M. Mercer:
Increase as a Percent of MCO Premium,
No Cap on Awards 44

10 Summary Comparison of Managed Care
Legislation Costs 48

Executive Summary

This report reviews nine studies of the impact of managed care reform legislation on health insurance premiums and managed care cost savings. A table at the end of the report presents a summary of the various published cost estimates of managed care reform legislation.

The studies examined are:

- a 1997 Milliman and Robertson study of the impact of eight provisions in PARCA on health insurance premiums — the composite effect of these provisions on premium increases is estimated to be 23%, and the "estimate range" of the premium impact ranges from 7% to 39%;

- a 1998 Muse & Associates study of the effects of the PARCA legislation on health insurance premiums — the enactment of PARCA is estimated to increase national premiums between 0.7% and 2.6%;

- a 1997 Lewin Group study of the costs and benefits of the information disclosure and external appeals provisions of the proposed Consumer Bill of Rights and Responsibilities — the information reporting and disclosure provisions are estimated to increase premiums between 0.3% and 1.3%, the external appeals provision is estimated to increase premiums no more than 0.05%;

- a 1997 Price Waterhouse assessment of the impact of expanded insurer liability, direct access to obstetric and gynecologic services, and lengths of stay for mastectomy patients — the impact on premiums of these provisions is fairly minimal, ranging from less than 0.1% to 1.3%;

- a 1997 Barents Group analysis of the impact of seven types of legislation or legislative elements affecting the cost saving from managed care; the analysis is general in nature rather than being carried out with respect to a specific legislative proposal — the estimated reduction in managed care savings relative to fee-for-service varies between 1 and 11 percentage points across the provisions;

- a 1998 Barents Group study of the potential cost of increasing plan exposure to malpractice liability, deeming utilization review to be the practice of medicine, prohibiting health plans from determining medical necessity and requiring plans to accept any willing provider — these types of legislation are estimated to increase managed care plans' costs by 2.2% to 8.6%;

- a 1998 Coopers & Lybrand analysis of the provisions in CBRR and PARCA dealing with information disclosure, access to emergency services, direct access to specialists, external appeals, a required point-of-service option for HMOs, and expanded health plan liability for medical decision making. Coopers & Lybrand present aggregate impact figures (excluding the effects of the expansion in plan liability proposed in PARCA) of 0.61% of premiums for the reforms in CBRR and 0.77% of premiums for the reforms contained in PARCA;

- a Congressional Budget Office analysis of the patient protection standards set out in the PBR — the provisions in the bill are estimated to increase premiums by 4% when all of the bill's provisions are fully phased in; and

- a William M. Mercer study of the cost impact of managed care accountability legislation — after considering a broad range of impact scenarios, premiums are estimated to increase between 0.1% to 1.8%.

Differences in the impact estimates between the studies are heavily dependent upon the interpretation of reform provisions and assumptions as to the extent of savings from managed care. The two studies prepared by the Barents Group for the American Association of Health Plans and the study prepared for Wal-Mart by Milliman & Robertson depict patient protection as very costly. Underlying these analyses, however, are extreme characterizations of proposed protections and exaggerated notions of cost savings.

Review of the estimates prepared by the Lewin Group, Muse & Associates, Price Waterhouse, Coopers & Lybrand, the Congressional Budget Office, and William M. Mercer all suggest that the effect of reasonable patient protection provisions on health insurance premiums is negligible. The Lewin results suggest that the additional costs of what are thought by many to be the most expensive patient protections are on the order of pennies per insured person per month.

The two most recent studies in this literature focused on the cost of expanding managed care plans' liability. The CBO estimated that expanding legal liability for ERISA plans would raise premiums among employer-sponsored plans by 1.2%. The CBO estimate may overstate the actual impact as it fails to account for the ability of managed care organizations to insure against liability claims at significantly reduced rates relative to providers. The estimate is consistent, however, with the range derived by William M. Mercer in an actuarial analysis of the impact of a model managed care accountability law. Mercer concluded that holding plans liable for damages to enrollees would add 0.1% to 1.8% to managed care organization premiums. If ERISA construction were narrow under the law, cost increases were predicted to be in the range of 0.5% to 1.8% of premiums.

Concerns about any cost increases associated with reform include potential losses of insurance coverage and reductions in the number of employed individuals. Several parties have inappropriately generalized an estimate of the impact of other reform legislation to suggest that a 1% increase in health insurance premiums is associated with a loss of insurance coverage for 200,000 individuals. The 1998 Barents study claims that each 1% increase in managed care plans' costs would result in a potential loss of insurance coverage for about 315,000 individuals. Neither of these estimates can be substantiated.

Introduction

This report reviews nine studies of the impact of managed care reform legislation on health insurance premiums and managed care savings. Two of the studies develop impact estimates of the provisions in H.R.1415/S.644, Patient Access to Responsible Care Act of 1997 (PARCA). A third examines the effect on premiums of two provisions from the proposed Consumer Bill of Rights and Responsibilities (CBRR). The fourth study assesses the impact of California managed care reform legislation on HMOs and their enrollees. The fifth analysis looks at general elements of legislative proposals that might alter the cost savings from managed care. The sixth study analyzes the effects of changes in four types of legislation on costs among managed care plans. The seventh report estimates the impact of adopting specific provisions of PARCA and CBRR on health care premiums. The next study presents cost estimates of seven major provisions of the Patients' Bill of Rights Act of 1998 (PBR). The last study assesses the cost impact of managed care accountability legislation.

The remainder of this report details the findings, methodologies, and critical assumptions underlying each of these studies.

Milliman & Robertson

Milliman and Robertson, Inc. (M&R) prepared *Actuarial Analysis of the Patient Access to Responsible Care Act (PARCA)*, (November 7, 1997) for Wal-Mart Stores, Inc. The report estimates the impact of eight provisions of PARCA on the nationwide average health insurance premium for the non-Medicaid, non-Medicare insured population. M&R calculate the composite effect of these provisions on premium increases to be 23%. The M&R report also provides an "estimate range" of the premium impact — 7% to 39%.

Exhibit 1
Milliman & Robertson
Patient Access to Responsible Care Act

Provision	Estimated Premium Impact
No Inducement to Reduce Services	[illegible]
Equivalent Reimbursement Rates In and Out-Of-Network	[illegible]
Elimination of Limits on Certain Benefits	[illegible]
Adverse Selection Against Rate Increases	[illegible]
Administrative Requirements	2.0%
Provision of Emergency Room and Urgent Care Services with Limits on Prior Authorization	0.5%
Mandatory Point-Of-Service Option	0.3%
Elimination of Prior Authorization for Specialty Referrals	0.2%

The characterizations of the studied provisions of PARCA and their estimated impacts on premiums are presented in Exhibit 1.

These numbers reflect M&R's "midpoint" estimates. M&R's interpretations of several provisions of PARCA are extreme or even misrepresent actual language in PARCA. Those interpretations drive both the high-end values of the range estimates and the mid-point

estimates of premium increases. The mid-point estimates are affected because M&R's "best estimate mid-points" are merely the mid-point of ranges whose high-end values are essentially capricious.

The estimates themselves are driven by a variety of assumptions about discounts, cost sharing, and use of capitation among HMOs, PPOs, and other plans. Several of the assumptions appear to have no basis in fact, and are undocumented by M&R. The report does not test the sensitivity of the estimates to changes in any of the underlying assumptions.

The four provisions indicated to have the largest potential impacts on premiums illustrate some of the particular problems in the analysis.

M&R characterizes Section 2771(d)(1)(A) of PARCA as **no inducement to reduce services**, which they interpret as not allowing risk sharing arrangements or capitated payments. The language in the bill, however, contains no mention of capitation, capitated payments, per-member per-month (PMPM) payments, or even an implicit reference eliminating or restricting those payment methods.

M&R interpret Sections 2772(b)(3), 2772(c)(2), and 2773(a), as constraining the ability of health insurance issuers to limit the number and scope of providers in their networks. In assessing the impact of these sections, M&R overstate the savings attributable to manage care and, thereby, overstate the impact of the legislation on premiums The average discount for HMOs is taken to be 28%, a magnitude that approaches the Medicare-to-private sector payment gap. In addition, M&R assume that 50% of HMOs use discounts and capitation, when the share of enrollees in such plans (which is clearly a smaller figure) is the relevant variable.

M&R characterizes Section 2772(b)(3) of PARCA as requiring **equivalent in-network and out-of-network reimbursement rate**, suggesting that health plans can not apply different deductibles, coinsurance, and copays to enrollees who use out-of-network providers vs. enrollees using in-network providers. That interpretation is in distinct contradiction to the Section's indication that "Nothing in this paragraph shall be construed as protecting an enrollee against balance billing by a health professional or provider that is not a participating health professional or provider."

M&R characterizes Section 2773(c) of PARCA as the **elimination of limits on certain benefits.** They assert that the provision could be interpreted as requiring health plans to cover services of professionals that currently are excluded from coverage by some plans. They state that such a provision would increase premiums by 1% for plans with rich benefits, and by 10% for plans with significant barriers to accessing such providers. The endpoints of their estimate range of premium increases due to this provision are based on the assumption that all plans are rich (the lower bound) and all plans have significant barriers (the upper bound). Clearly, both assumptions are extreme and fail to reflect the fact that any estimate of the effects of this provision should reflect the actual distribution of plans measured against these characteristics.

The **adverse selection** impact reported by M&R is a secondary effect of their estimated rate increases of the provisions analyzed. The concern that the report sought to address is the fact that increases in premiums caused by PARCA could result in healthier enrollees refusing coverage, which in turn, could cause a further increase in premiums. There is no documented basis for the 4.5% figure used by M&R.

A number of parties have seized on the M&R estimates to argue that PARCA would mean a sizeable increase in the number of **uninsured.** The underlying argument is that every 1% increase in health insurance premiums results in 200,000 people losing their insurance coverage. The latter calculation is based on, but not derived from, a CBO analysis of a mental health provision in a 1996 bill. CBO has indicated that the 1% -to- 200,000 translation should not be used as a rule-of-thumb in gauging the effect of legislation on the number of uninsured in general and is inappropriate for analyzing PARCA in particular.

Muse & Associates

Muse & Associates (M&A) was commissioned by the Patient Access to Responsible Care Alliance to evaluate the private sector health care premium impact of H.R. 1415/S. 644, the Patient Access to Responsible Care Act (PARCA). The report, *The Health Premium Impact of H.R. 1415/S. 644, the Patient Access to Responsible Care Act (PARCA)*, (January 29, 1998), contains estimates of the impacts of sections of the legislation. M&A calculate the enactment of PARCA would result in a national premium increase in the managed care health insurance market between 0.7% and 2.6%. Using the example of a $160 premium, PARCA would be expected to increase the premium to between $161.12 and $164.16.

The M&A study presents the estimated premium increases for provisions in PARCA likely to impact health costs and the secondary impact of adverse selection resulting from premium increases. The descriptions of the ten sections used by M&A and the magnitude or range of their impact on premiums are presented in Exhibit 2.

Exhibit 2
Patient Access to Responsible Care Act
Muse & Associates

Section	Provision	[illegible]
2771a	Enrollee Access to Care in Rural and [illegible]	[illegible]
2771b	Provision of Emergency Room and [illegible] Services with Limits on Prior Authorization [illegible]	[illegible]
2771c	Access to Medically Necessary Specialized [illegible]	[illegible]
2771d	No Inducement to Reduce Medically Necessary Services	[illegible]
2772b1	Choice of Point-Of-Service Option	[illegible]
2772b3	Equal Reimbursement for Providers Outside of Network	[illegible]
2773	Nondiscrimination Against Enrollees/Health Professionals	[illegible]
2777	Due Process for Health Professionals/Providers	[illegible]
2778	Information Reporting & Disclosure	0.3%-1.3%
4	Non-Preemption of State Law Respecting Liability of Group Health Plans	0.0%-0.2%
	Adverse Selection Against Rate Increases	0.1%-0.5%

The M&A estimates differ from the Milliman and Robertson estimates, in part, because the M&R analysis was based on draft language. The M&A analysis was developed using clarifying language for Section(s) 2771d, 2772b, 2773a, and 2773c.

The M&A analysis concludes that PARCA has only a minimal impact on utilization, and is unlikely to impact fees. Consequently, few of the provisions are expected to have substantial impacts on premiums. The M&A study also briefly discusses who will likely bear the increased premium costs due to PARCA. Based on a review of the employee benefits literature, the authors conclude that the majority of premium increases associated with PARCA would be borne by the workers — in the form of reduced wages, reduced fringe benefits, or higher health plan cost-sharing — and that employer labor costs are unlikely to increase significantly.

Because the majority of provisions are interpreted as having no effect on utilization or prices, the M&A analysis predicts a much smaller impact on premiums. The M&A impact estimates are driven by two key factors:

- Interpretation of the legislation as providing for no inducement to reduce medically necessary services, equal reimbursement for providers outside of network, and nondiscrimination against enrollees/health professionals; and

- Most provisions relating to options and services already widely available or accessible to enrollees. M&A assume that PARCA mandates no new benefits.

For those provisions estimated to have an increase on premiums, there is little description of the methods used to produce the estimates or discussion of the rationale for the assumptions used in those calculations. Much like the criticism of the M&R analysis of PARCA, it is impossible to assess the sensitivity of the M&A estimates to changes in the assumptions.

The key factor determining the M&A impact estimates, and consequently explaining a large share of the difference between their estimates and those presented by M&R, is the interpretation of three sections of the PARCA legislation. The three sections (provisions) — **no inducement to reduce medically necessary services, equal reimbursement for providers outside of**

network, and nondiscrimination against enrollees/health professionals — in the M&R analysis account for most of the estimated 23% increase in premiums. M&A assert that the M&R interpretation of these provisions as eliminating risk sharing, capitation, and provider discounts is unwarranted and assume that managed care organizations will continue to receive discounts. Consequently, the legislation is expected to have little or no effect on health care prices. M&A estimate those three provisions have a minimal (<0.05%) effect on premiums.

A second factor, in the form of either "almost all" or "most" managed care plans already provide the mandated services or plan options to enrollees, or restriction are not "...a widespread practice," is used to explain why **the provision of emergency room and urgent care services with limits on prior authorization, access to medically necessary specialized treatment**, and several other sections are found to have "minimal premium increase effect." There are generally no documented measures of the proportion of plans, accompanied with the number of enrollees in those plans, which would comply with the provisions in PARCA.

The **adverse selection** impact reported by M&A (0.1% - 0.5%) is derived from the M&R estimate. This impact captures the effect of increased premiums caused by PARCA resulting in healthier enrollees refusing coverage, which in turn could cause a further increase in premiums. The estimated range, 0.1% to 0.5%, for the impact of adverse selection on premiums is derived as a proportion of the total impact based on the midpoint estimate of M&R, 4.5%/23%. There is no documented basis for the 4.5% impact assumed by M&R.

M&A rely on the M&R estimate for the effect on premiums of the **point-of-service** option provision (0.3%) and argue that M&R's use of actual claims data are a valid data source for estimating the impact on premiums of this section of the legislation.

The M&A estimated impacts of the **information reporting and disclosure provisions** (0.3% - 1.3%) are taken from the Lewin Group study "Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals," Presidential Advisory Commission on Consumer Protection and Quality in Health Care Industry, Final Report, November 1997.

The estimated costs of information disclosure ranges between $0.59 and $2.17 per insured person per month. Based on a $170 per month managed care premium, M&A estimate that information reporting and disclosure provisions would increase the premium between 0.3% and 1.3% ($0.59/$170 or 0.3%, and $2.17/$170 or 1.3%). (In other parts of report, M&A uses a $160 premium.) In the Lewin Group study, the low-end estimate represents a three to five year phase-in period, which assumes that the cost of information acquisition and distribution will fall substantially over time.

Finally, M&A estimate the impact on premiums of **the non-preemption of state law respecting liability of group health plans** section of PARCA (0.0% - 0.2%). The authors of the study derive the impact estimate using a 1992 Congressional Budget Office estimate of 1998 national medical injury and litigation costs ($36 billion); an unspecified estimated ratio of the managed care sector of the health insurance market; and an assumed four percent increase in medical injury premiums.

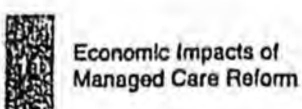
Lewin Group

The Lewin Group report *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals, Final Report* (November 18, 1997) was commissioned by the Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry. The report contains estimates of the impact of the information disclosure and external appeals provisions of the proposed Consumer Bill of Rights and Responsibilities. These are two of the seven areas of consumer rights under consideration by the Commission. The analysis was limited to administrative costs and did not examine the effects of information and external appeals on utilization. The Lewin study also describes the nature of possible benefits of those provisions, but does not quantify the dollar value of the benefits.

The per-person, per-month cost of information disclosure is estimated to range between $0.80 and $2.17 for one year, and between $0.59 and $1.10 for a three to five year phase-in period. Based on a $170 per month managed care premium, the information reporting and disclosure provisions would increase premiums between 0.3% and 1.3%. The cost estimates for external appeals (excluding states with mandated external appeals systems) ranged from $0.003 to $0.07 per person per month. Based on the $170 per month managed care premium, the effect of the external appeals provisions on premiums would be less than 0.05%.

The information disclosure provisions of the Consumer Bill of Rights Responsibilities (CBRR) recommend that consumers have access to a broad range of information on the characteristics, policies, procedures, experience, and performance of physicians, facilities, and plans. This information should include:

- Health plans: Covered benefits, cost-sharing, and procedures for resolving complaints; licensure, certification, and accreditation status; comparable measures of quality and consumer satisfaction; provider network composition; the procedures that govern access to specialists and emergency services; and care management information.



- Health professionals: Education and board certification and recertification; years of practice; experience performing certain procedures; and comparable measures of quality and consumer satisfaction.

- Health care facilities: Experience in performing certain procedures and services; accreditation status; comparable measures of quality and worker and consumer satisfaction; procedures for resolving complaints; and community benefits provided.

The provisions related to appeals recommend that consumers have the right to a fair and efficient process for resolving differences with their health plan, health care providers, and institutions that serve them; and that consumers have access to a rigorous system of internal review and an independent system of external review of plan decisions. The CBRR posits that an external appeals systems should:

- Be available only after consumers have exhausted all internal processes (except in cases of urgently needed care).

- Apply to any decision by a health plan to deny, reduce, or terminate coverage or deny payment for services based on a determination that the treatment is either experimental or investigational in nature; apply when such a decision is based on a determination that such services are not medically necessary and the amount exceeds a significant threshold or the patient's life or health is jeopardized.

- Be conducted by health care professionals who are appropriately credentialed with respect to the treatment involved and subject to conflict-of-interest prohibitions. Reviews should be conducted by individuals who were not involved in the initial decision.

- Follow a standard of review that promotes evidence-based decisionmaking and relies on objective evidence.

- Resolve all appeals in a timely manner with expedited consideration for decisions involving emergency or urgent care consistent with time frames consistent with those required by Medicare (ie, 72 hours).

The Lewin report noted that no definitive studies have been conducted in these areas because information disclosure and external

appeals processes are just now being developed. Consequently, the authors relied on a literature review for context and a series of interviews to provide cost information as it relates to current and on-going information and appeals efforts.

Actual cost data from a variety of projects are used to estimate the costs of several aspects of information disclosure and external appeals. While the estimates are derived from cost figures of ongoing activities, the end-points of the range of these "estimates" are still based on sample sizes of one. The report does, however, provide detailed information on the sources of data, the specific calculations, assumptions, and other elements which would allow for testing the sensitivity of the estimates.

The cost estimates for the **information disclosure** provisions constructed by Lewin are intended to be incremental; they measure costs of efforts beyond the current state and private activities. See Exhibit 3. The low-end estimate assumes a three to five year phase-in implementation period and that as information becomes more widely available and information technology advances, the cost of information will fall substantially.

Exhibit 3
Lewin Group Information Disclosure Cost per Insured Person per Month

[illegible]	[illegible]
[illegible]	[illegible]
Low Estimate	[illegible]
Mid-Point Estimate	[illegible]
High Estimate	[illegible]

Estimates are also presented on a category by category basis for physicians, hospitals, and plans separately. The categories include characteristics, experience, customer satisfaction, and quality. See Exhibit 4.

Exhibit 4
Lewin Group Midpoint Estimates for Information Disclosure
3-5 Year Phase-In

[illegible]	Characteristics	[illegible]	[illegible]
Physicians	$0.002[illegible]	[illegible]	
Hospitals	$0.12	[illegible]	
Plans	$0.1[illegible]	[illegible]	
Sub-total	$0.26[illegible]	$0.0[illegible]	$0.[illegible]
[illegible]	[illegible]	[illegible]	Dissemination [illegible]
			Total [illegible]

The incremental cost of providing the information required by CBRR is estimated to be relatively small. Behind these calculations, however, several assumptions are questionable:

- the average survey cost per enrollee for plan customer (patient) satisfaction information, between $0.045 and $0.14 — which is less than a first-class stamp, and

- the costs to physicians to collect quality data based on medical records, $160 per physicians per year provisions.

Consequently, the Lewin estimates may be low-end estimates of the costs of implementing CBRR information disclosure.

The estimated costs of external appeals presented range between $0.003 to $0.07 per person per month. The range of estimates was driven by assumptions concerning appeals rates per 1000 persons and how external appeals are processed. In Florida, the appeals rate is 0.000093 per enrollee. Whereas for the Medicare population, the rate is 0.001 per enrollee. The actual costs of appeal also vary considerably across states. In Florida, the state panel has an average cost of $867 per appeal. The cost among appeals in Texas, Rhode Island, and New Jersey, which use independent review contractors, ranges from $288 to $600 per appeal. Lewin uses an "average" cost from those states of $450 per appeal, the $867 per appeal from Florida, and the appeals rates from Florida and Medicare to construct their range of estimates. If these figures are not representative of national ranges of costs and appeal rate, however, external appeal costs could be outside of the range presented by Lewin.

Price Waterhouse

Price Waterhouse (PW) was commissioned by the Henry J. Kaiser Family Foundation to assess the impact of managed care reform legislation on HMOs and their enrollees. The report, *The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals in California*, analyzes insurer liability, use of drug formularies, mental health parity, direct access to obstetric and gynecologic services, and lengths of stay for mastectomy patients. The impact estimates of the first and last two legislative areas are reviewed in this report.

PW examines the specifics of the legislative bills in California, the likely impact of the legislation on HMOs by organizational type, and the corresponding effects for consumers. The estimated impacts are broken out by type of HMO plan, i.e., staff model, group model, network model, and independent practice/physician association (IPA) model. Other forms of managed care plans — preferred provider organizations (PPOs) and point-of-service plans (POSs)— are excluded from the analysis.

The authors of the PW study present a relatively detailed description of the methodology utilized to derive the impact estimates. In places, the methodology relies upon unsubstantiated assumptions and national (rather than California-specific) utilization and spending data. The data used are taken from aggregated categories of services, rather than the specific services targeted in the legislation. Of particular concern is the failure to account for differences between the structure of the national health care delivery and financing system and the structure of that system in California. National data will be partially driven by the nationwide mix of plans — indemnity, staff model HMO, group model HMO, network model HMO, independent practice/physician association (IPA) model, preferred provider organizations (PPOs) and point-of-service plans (POSs) — and hence, may not be appropriate for constructing state-level estimates. Finally, the authors of the PW study base their expectations regarding service utilization differentials across plans on relative "incentives" across plans. But the specific incentives and payment mechanisms are unspecified.

Expanded liability is expected to have a minimal impact on premiums. Theoretically, the non-preemption of state law regarding liability of group health plans mandate should not change the amount of liability or risk in the system. The burden of risk, however, would be redistributed from providers to plans. As risk is shifted to plans, and away from providers, the part of the health insurance premium paid to providers and others to compensate them to bear risk (the "risk premium" in economic terms) would also be shifted to plans to cover their cost of increased liability. Overall, the change in the premium would be minimal. Price Waterhouse estimates the impact on IPA model HMO premiums to be between 0.1% to 0.4%.

The effect of California legislation, AB 1354, providing women **direct access to obstetricians and gynecologist services**, on premiums is expected to be minimal. This is partially due to the fact that in 1994 California enacted legislation enabling women to choose an obstetrician and gynecologist (OB/GYN) as their primary care physician. The legislation, AB 1354, expands upon the 1994 legislation by requiring health plans to provide women with direct access to obstetrical and gynecological services. PW estimate that direct access would increase premiums and out-of-pocket costs 0.35% for (staff model) HMO, IPA model, and group model HMO enrollees.

The PW estimate of the cost of those provisions is problematic because the data on spending, utilization, and physician fees used in developing the estimates are national measures, not California specific. Since women in California could already choose a specialist in OB/GYN as their primary care physician, some measure of the extent to which women nationwide have that choice and how it impacts the number of visits per year should be accounted for in constructing the estimates. This effect may have caused PW to overstate the costs of AB 1354. In addition, a measure of the relative cost of OB/GYN versus FP/GP services comes from AMA data on the average fee for an office visit of an established patient. In addition to being a national average, the data refer to a series of CPT codes which have a fairly wide variation in the level of complexity. Consequently, differences in fees across specialties are at least partially determined by differences in the mix of services provided by those specialties.

The enactment of a **48-hour minimum stay for mastectomies** is estimated to result in a 0.01% increase in premiums, for both IPA

model and group model HMOs. That estimate is based on national data and assumptions which are not substantiated. For example, while no source is given, the average per day cost for hospital stays ($1,025) appears to be a national average, over all inpatient procedures. National measures of the relative utilization rates across plan types are drawn from MEDSTAT data. Yet plan type on the MEDSTAT files are often missing or recoded to "other."

Finally, there is no stated basis for the assumption that between 25% and 30% of short-stay patients (those who would have previously stayed less than 48 hours) would elect to stay the full 48 hours. Nonetheless, even if that share of patients were to double, the low-end estimate of the premium impact of mandating minimum LOS for mastectomies would still be less than a 0.05%.

Barents Group (1997)

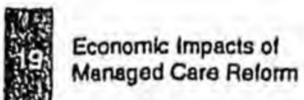
Barents Group, LLC has published two reports that discuss cost implications of managed care reform legislation. *The Effects of Legislation Affecting Managed Care on Health Plan Costs* (May 5, 1997), was prepared for the American Association of Health Plans. The report identifies seven types of legislation or legislative elements that would alter the way managed care firms do business. The analysis is general in nature rather than being carried out with respect to a specific legislative proposal.

The legislative provisions analyzed in the report and their estimated reduction on savings from managed care relative to fee-for-service are as follows:

- **Mandated Point-of-Service Option (MPOS)**, characterized as requiring either that health care plans that offer a closed-panel option also offer a point-of-service (POS) option or that employers that offer employees a closed-panel health plan also offer a POS option. Barents estimates that this type of act could reduce premium savings by 4 to 11 percentage points for those employers who do not currently offer a point-of-service option.

- **Direct Access and Freedom of Choice**, characterized as giving plan members the opportunity to obtain services without referral from their primary care provider. Direct access is used to refer to legislative provisions that cover treatment within the plan's provider network while freedom of choice is used to refer to provisions that would allow plan enrollees to seek treatment outside of plans' provider networks. Barents estimates that direct access provisions would reduce cost savings to group and staff model HMOs by 9 percentage points and that freedom of choice provisions would reduce savings for HMOs by 16 percentage points and by 9 percentage points for IPAs.

- **Establishment and Maintenance of Health Care Provider Networks**, often characterized as due process provisions, would require appeal mechanisms for denied medical treatment and would regulate the nature of contracts between plans and providers by requiring, for example, written processes for termi-



nation of a provider's contract. Barents suggests that HMO savings would be reduced by 8 percentage points; PPO/POS savings by 5 percentage points.

- **Prohibition of Physician Incentive Payments**, eliminating the use of financial incentives such as bonuses and withholds by managed care plans, is estimated to reduce HMO savings by 3 to 5 percentage points.

- **Restrictions on Utilization Review (UR)**, imposing restrictions on how managed care organizations design and implement utilization review, such as requiring that only a health care professional of the same specialty as the practitioner and who resides in the same state could refuse to certify payment for a service. Barents estimates that such restrictions would reduce HMO savings by 3 to 5 percentage points.

- **Care Delivered in Emergency Rooms**, characterized as requiring that plans cover and reimburse expenses for any emergency room or urgent care obtained, without prior authorization and without limits on the provision of these services. Barents estimates that costs in managed care plans would rise by 1 - 3%, excluding post-stabilization care.

- **Expanded Health Plan Liability** legislation would make managed care plans liable for failure to provide a covered service and for the actions of providers and other agents of the plan. Barents estimates a 4 - 5% increase in costs for IPA and PPO/POS plans.

The estimates in the Barents Group (1997) report are driven by assumptions as to the savings in managed care plans that accrue through utilization review, utilization management and price discounting. Barents assumes that these tools enable staff and group model HMOs, IPAs, and POS/PPO plans to reduce costs by 30, 23, and 14%, respectively, relative to traditional indemnity.

Understanding the composition of each of these three managed care savings assumptions provides a critical perspective on the Barents estimates. Exhibit 5 contains the managed care health plan savings relative to fee-for-service plans used in the Barents (1997) study.

Exhibit 5
Barents (1997) Percent Savings Relative to Traditional Indemnity

	[illegible]	[illegible]
Utilization Review	4	[illegible]
Utilization Mgmt	4	[illegible]
Price Discounts	6	[illegible]

The fourth column of numbers (All HMOs) reflects the current mix of HMOs in the market and is calculated as the market share weighted average of the IPA (70%) and Group/Staff model HMO (30%) figures. All of the plan types considered in the Barents report, including managed fee for service, achieve a 4% savings relative to traditional indemnity. Traditional indemnity, of course, is a bit of a strawman in the Barents analysis since currently such coverage is the rare exception, not the rule.

The figures used for utilization management savings are high relative to careful review of the literature. Barents notes that the February 1995 CBO report generally credited forms of managed care other than group and staff model HMOs with very low utilization effects. The Barents report cites two works (which had been reviewed as part of the CBO analysis) and suggests that those works provide a sense of the true effects of utilization management in such plans. It ignores the broader range of studies reviewed by CBO and rejects the conclusion by CBO that IPAs reduce utilization by less than one percent.

The Barents report also suggests that IPA efficiency has improved over time. It attempts to support the notion by appealing to a March 1997 CBO study, Predicting How Changes in Medicare's Payment Rates Would Affect Risk-Sector Enrollment and Costs, which found greater IPA utilization impacts for the Medicare population than past CBO analyses. However, as that CBO report noted, improved IPA efficiency is only one explanation for the expenditure differentials in that report. Another explanation offered by the CBO is increased favorable selection and statistical models that inadequately identify the selection.

In the CBO's March 1994 report, it was noted that PPOs have a mixed score card on utilization reduction because of generally

low cost sharing. CBO estimated that PPOs achieve a 2% savings relative to unmanaged fee for service arrangements. Finally, although the Barents report based its utilization savings figure for group and staff model HMOs on the 1995 CBO report estimate, the latter likely overstates the true effect due to an econometric error in the treatment of self-selection in the CBO analysis. Sensitivity tests reported by CBO suggest that the utilization savings attributable to all HMOs is probably on the order of the 3.9% found in their March 1994 analysis. The latter analysis also contains errors, but they partially offset one another.

The savings estimates used for price discounts accruing to HMOs have no scientific basis. The Barents report indicates that there is no available evidence of the extent of discounting realized by staff/group model HMOs, and that it arbitrarily uses half the IPA savings figure. The 15% figure for IPAs is derived from an analysis by Lewin-VHI that was based exclusively on data (for a small number of markets) provided by Aetna. It's unlikely that typical IPAs can extract provider discounts as large as a major insurer such as Aetna. In any event, the data used in the analysis were actuarial projections, not actual claims or premium data. The 13% figure for the all HMO category is the weighted average of the other two figures.

Finally, it should be noted that the design of the Barents analysis prohibits its usefulness in examining particular pieces of legislation. That is because many of the effects analyzed would be overlapping and aggregating the individual estimates would constitute double counting.

Barents Group (1998)

The second report by the Barents Group, *Impacts of Four Legislative Provisions On Managed Care Consumers: 1999 - 2003* (April 22, 1998), was also prepared for the American Association of Health Plans. The report estimates the potential costs of four types of legislation that are either under consideration or have been adopted into law at some level. Estimated changes in health insurance costs are calculated in terms of percent increases in plan premiums and are used to project changes in spending on coverage for the 1999 to 2003 period. Baseline estimates of spending on managed care premiums by employers, households, and governments from 1999 through 2003 were developed in a separate Barents Group report.

The four types of provisions examined in the Barents Group (1998) study and their estimated impacts are as follows:

- **Increasing exposure of health plans to malpractice liability** - H.R. 1415 proposed by Representative Norwood (R-GA) and H.R. 3605 proposed by Representative Dingell (D-MI) are identified as examples of legislation that would eliminate Employee Retirement Income Security Act (ERISA) preemption of state law causes of action against health plans sponsored by private employers. Barents estimates that this type of legislation would increase managed care plans' costs by between 2.7% and 8.6%.

- **Deeming utilization review to be part of the practice of medicine** - Barents cites New Mexico Senate Bill (SB 862; enacted in 1994) as an example of this type of legislation. This provision is estimated to increase managed care plans' costs by between 2.2% and 6.9%.

- **Prohibiting health plans from playing any role in making medical necessity determinations when making coverage decisions** - The medical necessity law contained in the proposed Federal Health Insurance Bill of Rights Act of 1997 (S. 373), sponsored by Senator Kennedy (D-MA) was analyzed by Barents. Restricting plans from making medical necessity determinations for purpose of coverage decisions is estimated to increase managed care plans' costs by between 4.1% and 6.1%.

- **Requiring plans to allow any willing provider (AWP) in their network if the provider meets certain qualifications and is willing to abide by plan requirements** – Barents examines the AWP provisions of Tennessee's "Patient Advocacy Act of 1997" (SB 1767). The adoption of any willing provider laws is estimated to increase managed care costs by between 6.6% and 8.6%.

The managed care savings assumptions employed in the Barents (1998) analysis are presented in Exhibit 6. Those assumptions, which are central to the Barents analysis, are based on the managed care savings estimates used in the Barents (1997) analysis and an assumed 4 percentage point increase in savings attributable to IPAs. Our discussion of the Barents (1997) savings estimates indicates that there is substantial upward bias in those numbers and a report from the Medicare Payment Advisory Commission (Greene 1998) indicates that new IPA cost savings may be attributable to increases in favorable selection experienced by Medicare HMOs. That report found that disabled and chronically ill Medicare beneficiaries have lower rates of enrollment in Medicare managed care than other groups of beneficiaries.

Exhibit 6
Barents (1998)
Percent Savings Relative to Traditional Indemnity

[illegible]	POS/PPO	[illegible]	[illegible]	[illegible]
Utilization Review	4	[illegible]	[illegible]	[illegible]
Utilization Mgmt.	4	8	[illegible]	[illegible]
Price Discounts	6	15	[illegible]	[illegible]

As with the initial Barents analysis, many of the effects analyzed in the 1998 Barents study overlap. In other instances, the report aggregates the cost of mutually exclusive outcomes. For example, adding the cost impact of an expansion in plan liability absent any change in utilization review to the cost of a change in utilization as a result of plan "defensive medicine" constitutes clear exaggeration of the true cost impacts of expanded liability.

The legislative proposals cited in the Barents (1998) study remove the ERISA preemption provision by varying degrees. The analysis presumes, however, that in expanding managed care organizations' malpractice liability, the ERISA preemption would be eliminated.

Obviously, some reform bills (e.g., H.R. 3605) have more limited or targeted removal of ERISA preemptions. A broader ERISA preemption of actions against managed care organizations would generate small increases in the direct cost of liability insurance.

The Barents (1998) study classifies the effects of **legislation that expands managed care organizations' exposure to malpractice liability** as direct costs (malpractice insurance premiums, contributions to liability self-insurance funds, and uninsured losses from malpractice claims) and indirect costs (defensive medicine). Direct effects are estimated to range between 0.9% and 1.4%. Indirect effects are estimated to range from 1.8% to 7.2%. These figures combine to a total cost estimate of between 2.7% and 8.6% of premiums.

Direct effects are based on the costs of health plan liability insurance, the number of plans that will have to obtain liability insurance, and the average increase in premium costs because of the increased probability of being subject to malpractice suits. The study uses two baseline scenarios and two different assumptions about the number of managed care plans that would need to purchase medical liability coverage if such legislation were passed. The analysis assumes that the number of claims filed will increase due to the presence of new (and deep) pockets, that the number of successful malpractice suits will increase, and that the average value of awards will increase.

For the low-end estimate, all plans are assumed to have liability insurance and the baseline liability costs are assumed to be 0.5% of plan premiums. The latter figure is based on a small sample of insurers' liability premium costs. Total direct effects for the low-end estimate are driven entirely by the assumption that plan liability costs expressed as a percentage of plan premiums increase to the level of hospital liability costs expressed as a percentage of revenues, after the expansion in plan liability. For the high-end estimate, Barents assumes that 34% of plans will need to obtain liability coverage that they do not already have and that baseline liability costs are 2.0% of plan premiums. The baseline figure of 2.0% was chosen to be greater than the level of hospital liability expenses, yet below the level of physician liability expenses. The analysis then assumes that liability increase to a "weighted average of physician and hospital premium costs," or 2.5%. The resulting estimated range of direct cost increases is between 0.9% and 1.4%.

The use of hospital and physician liability costs as baseline for Barents's high-end estimate scenario and the use of such costs, in both scenarios, in gauging the increase in direct liability costs clearly introduces significant upward bias into the analysis. The only plan specific information on liability costs as percent of plan premiums presented by Barents was 0.5%. Yet the high-end estimate baseline, 2.0% of plan premiums, is 4 times that figure and factors into Barents's estimate of a 0.9% addition to costs due to plans obtaining coverage that they are presumed to currently be without. The only other figure in the high-end scenario estimate of direct costs, the 0.5% increase in liability insurance premiums, is driven by Barents use of hospital and physician liability costs. Managed care organizations, however, enjoy an obvious advantage relative to providers in obtaining liability coverage - they deal with insured populations large enough to take full advantage of the law of large numbers. In other words, and as the data presented by Barents suggest, managed care organizations should be able to insure against malpractice liability at significantly reduced rates relative to providers.

The Barents report proposes that managed care liability provisions create incentives for plans to loosen utilization review restraints, i.e., to practice defensive medicine. Considerable care needs to be taken in analyzing this potential effect. In the Barents analysis, any resultant increase in services delivered should be measured in lieu of, rather than in addition to, the direct effects of increased exposure to malpractice liability. The Barents analysis fails to account for the reduction in liability exposure which defensive medicine is intended to offset. Consequently, a form of double counting exists in the Barents cost estimates.

The double counting aside, the Barents estimate of the indirect effects is overstated because of its assumption that defensive medicine currently comprises 9% of fee-for-service spending and, at least in the case of its high-end estimate scenario, an unrealistically high assumption as to the potential extent of defensive medicine in the U.S. absent utilization management by plans. The estimate that 9% of fee-for-service spending is defensive medicine is drawn from a study of defensive medicine associated with hospital expenditures in treating serious heart disease among elderly Medicare beneficiaries. It is used in both the high-end estimate and low-end estimate scenarios. Under the low-end scenario, Barents assumes that current UR/UM activities have eliminated 20%

of defensive medicine. In the high-end scenario, Barents assumes that current utilization review and management activities have eliminated 80% of defensive medicine. The indirect effects are assumed to be an expansion in defensive medicine by plans, to the full extent practiced by physicians, and are thus estimated to be 1.8% (9% x 20%) to 7.2% (9% x 80%), respectively.

The assumption that 9% of health care spending is defensive medicine constitutes a clear and upward bias in the analysis. The Barents report applies the 9% figure for fee-for-service utilization to managed care spending broadly - ignoring capitation and withhold arrangements. Moreover, the treatment of serious heart disease among the elderly population can not be construed as being representative of variations in treatment levels in medical services generally and the analysis should be objected to on that basis alone. The level of defensive medicine assumed by Barents exceeds even high-end published estimates of the extent of defensive medicine (taken as a share of national health spending) by a factor of almost 5 (Lewin-ICF 1992). Secondly, there is no basis for the assumption that 80% (or even 20%) of defensive is eliminated by current UR/UM practices. The assumptions that current UR/UM activities have eliminated all but 20% of defensive medicine and that defensive medicine comprises 9% of current total health care spending logically indicate that 45% (5 x 9%) of total health care expenditures would be defensive medicine absent current utilization controls. Even the most extreme findings from the utilization variations literature fail to support such a number.

The failings identified in connection with the Barents analysis of indirect costs of an expansion in plan liability are damaging to claims that such legislation would be costly. Indirect costs in the Barents report comprise 67% of their low-end estimate and 84% of their high-end estimate. Their indirect cost estimates additionally feed into the cost estimates of other managed care reforms.

The estimated cost of legislation **defining UR as a practice of medicine** is based on the assumption that this type of legislation would impose medical malpractice liability on plans. The impacts of such legislation would be comparable to those identified in the discussion of more general liability provisions. The Barents study indicate that defining UR as the practice of medicine would result in slightly lower direct costs for liability insurance increases (about one percent at the high end) and that indirect costs would be

reduced by about 20%. Applying this formula would generate an estimated range of 2.3% (0.09 + 0.8 x 0.027) to 6.2% (0.01 + 0.8 x 7.2). The estimated range of costs presented in the report is actually calculated by taking 80% of the low-end and high-end values from the cost of extended managed care liability laws: 2.2% (0.8 x 0.027) to 6.9% (0.8 x 0.086). In either case, the approach taken by Barents results in estimates that are substantially biased upward. This is because the estimates depend critically on the exaggerated estimates of the costs of expanded liability.

The estimated increase in cost resulting from **medical necessity** law is based on the exaggerated figures used for UM savings. The Barents study suggests that in an extreme case, plans could lose all ability to control utilization and costs through UM activities. The study suggests that between 60% and 90% of utilization management savings would be lost if such a provision were enacted. The two scenarios considered employ additional extreme assumptions — at the high-end, slightly less than the absolute maximum savings is lost, and at the low-end, the majority of savings is lost. Such assumptions clearly rule out a broad range of potential adjustments by plans.

The cost estimates of **any willing provider** legislation are based on extreme interpretations of laws that eliminate plans' ability to reduce utilization of services and to obtain price discounts from providers. Barents refers to adopting the conservative estimate that the "due process" provision would reduce IPAs' ability to control costs to those levels currently attributable to PPOs and POS plans — a 13 percentage point loss of savings for IPAs - and that group and staff model HMOs' ability to reduce costs would also decline to the levels for PPO and POS plans — a 16 percentage point loss of savings for group and staff HMOs. It is also assumed that POS and PPO plans still receive some price discounts from providers, allowing them to maintain a five-percent cost difference from managed fee-for-service.

A review of a small number of studies is used to estimate the costs of AWP laws. The authors present no review or critique of any study cited. Two of the studies (Wyatt 1991; Atkinson & Company 1994), however, have significant shortcomings. The cost estimates from the first study are imprecise because the data used to construct the estimates are derived from a very small, unrepresentative sample of firms. Moreover, both studies assume administrative

costs per physician rise with the size of the physician network. With a large portion of those costs being fixed over a wide range of providers, economies of scale may reduce average administrative cost per provider. The Atkinson & Company cost estimates are additionally based on undocumented assumptions about physician excess capacity and changes in HMO participation brought about by AWP laws that render the estimates meaningless.

Finally, the Barents study states, without justification, that every 1% increase in managed care costs at the national level has the potential to increase the uninsured by about 315,000 individuals in 1999. This exceeds even the 1% -to- 200,000 translation that the CBO dismissed in connection with the M&R estimates.

Coopers & Lybrand

The Coopers & Lybrand (C&L) report, *Estimated Costs of Selected Consumer Protection Proposals: A Cost of the President's Advisory Commission's Consumer Bill of Rights and Responsibilities and the Patient Access to Responsible Care Act* (April 1998), was prepared for the Henry J. Kaiser Family Foundation. The C&L report focuses on the provisions of those two bills deemed to have the greatest potential effect on costs and to be reasonably precise in interpretation. On a PMPM basis, C&L report an aggregate impact of 0.61% of premium for the four provisions of the Consumer Bill of Rights and Responsibilities examined and 0.77% for the five provisions of Patient Access to Responsible Care Act costed out.

The C&L report points out that its cost estimates relate specifically to expected changes in costs for HMOs and that the cost impacts of the analyzed consumer protections, examined in the context of the entire health insurance market, would be lower than the values contained in the report.

Exhibit 7
Coopers & Lybrand Consumer Bill of Rights & Responsibilities and Patient Access to Responsible Care

Provision	[illegible]
CBRR	
Information disclosure	[illegible]
Emergency service access	[illegible]
Access to specialists	[illegible]
External appeals	0.08%
PARCA	
Information disclosure	0.08%
Emergency service access	[illegible]
Access to specialists	0.02%
External appeals	0.08%
Point of service option	0.48%

The studied provisions of the two proposals, and their estimated impact on premiums, are presented in Exhibit 7.

The report discusses, but does not attempt to measure, the cost impact of changes in medical liability that would occur under PARCA.

The C&L estimates were developed using a combination of actuarial data, estimates of savings from managed care relative to fee-for-service, and key assumptions based on C&L's review of the literature. The estimates of managed care savings, which are central to the analysis, are not identified in the report. In general, however, the report appears to be solid.

The C&L report notes that the **information disclosure** requirements of the two proposals are a mix of currently collected information and new information. The CBRR report recommends extensive data collection and disclosure for health plans, facilities, and professional providers such as physicians. PARCA limits reporting requirements to health plans. C&L note that many of the information collection and dissemination requirements reflect standards already evolving in the managed care market. New information disclosure requirements in the two proposals examined relate to satisfaction, quality, quantity of services, and certain participating provider characteristics.

The cost analysis of this set of provisions is based on the Lewin Group analysis of CBRR. The C&L estimate differs from the Lewin estimate, however, because it assumes lower labor costs in collecting health plan and hospital data. In addition, it does not assume that some information would necessarily be distributed in hard copy form to all insured lives. Rather it envisions that information would be distributed on request and that centralized distribution through the Internet would emerge.

The C&L report notes that the information disclosure is likely to spur competition at all levels of the health care system and that just a 1% decrease in average HMO premiums would offset the costs of such requirements. Plans stand to benefit from the new data collection requirements as well. Analyses of enrollee satisfaction data (required under the CBRR) would enable plans to improve both individual and employer retention rates.

Both CBRR and PARCA would require that health plans use a prudent layperson standard for **access to emergency services**. C&L

indicate that the standard is generally construed to mean that plans must pay for the initial costs of emergency care of any individual who believes that emergency treatment is necessary due to potentially long term damage or to excessive pain. Neither proposal extends plans' responsibility to the coverage of ongoing treatment in an emergency facility. The CBRR would require plans to educate enrollees as to the location and appropriate use of emergency services, and would require emergency departments to contact primary care providers to discuss follow-up and post-stabilization care.

C&L use actuarial data on the rate of denials of emergency room visits by HMOs relative to the HMO utilization rate. This approach is more direct than the alternative approach of comparing HMO and fee-for-service emergency room utilization rates. Based on an average cost of $120 per visit, an average HMO utilization of emergency room services of 0.26 visits per member per year, and a 5% denial rate by HMOs, C&L calculate that the cost of this provision to be $0.10 PMPM. The report notes that most plans already comply with the prudent layperson standard.

Provisions in CBRR and PARCA also indicate specific standards for **access to specialists**. Both would require plans to use standing referrals to specialists for individuals with complex or serious medical conditions who need frequent specialty care. The Federal Employee Health Benefits Program has adopted a similar standard. Such a change is likely to significantly increase member satisfaction — especially among members with chronic, ongoing conditions. C&L note that standing referrals would entail an initial screening visit with the covered individual's primary care provider and thus the standard is distinct from direct access to all specialty care. The CBRR would additionally require plans to allow women to choose among qualified providers offered by the plan for the provision of covered routine and preventative women's health care services.

The C&L report indicates that most plans already comply with the standards considered. Actuarial data analyzed by C&L suggest that the provisions in CBRR would add 0.02% of premiums to plan costs. The provisions in PARCA, which are less extensive in scope but less specific as well, are similarly projected to add 0.02% of premiums to plan costs.

The C&L report notes a number of large health plans have recently

implemented **external appeals** processes. Plans holding Medicare or Medicaid contracts already are required to have such processes. Plans holding contracts with the Office of Personnel Management to cover federal employees are subject to external review requirements. Finally, at least fourteen states have passed legislation requiring an external appeal process.

The cost estimate for this provision is developed using the number of appeals per 1000 in Florida (reported in the Lewin Group analysis of the CBRR) as their low-end approach and a 500% increase in that number for their high-end estimate. They assume that all external appeals would be conducted by physicians, at an average cost per hour of $250 to $300, and that the average appeal would take 4 hours. They also assumed that plans have internal appeals processes sufficient to ensure that only 15% of appeals are overturned externally, at an average claims cost of $5,000 to $15,000. These figures suggest that costs from external appeals would not exceed 0.08% of premium.

PARCA would require all network-model HMOs to offer an **optional Point-of-Service** (POS) plan to all members. The C&L report indicates that POS plans typically enable members to obtain out-of-network benefits at a cost (to the member) of 20% to 30% over in-network costs. The administrative systems of such plans are potentially complex and pose the greatest challenge to staff and group model HMOs that reimburse physicians on a salary or capitated basis. Regulation of POS plans varies substantially by state. Self-funded plans are governed by ERISA.

For plans that do not offer a POS option (assumed by C&L to be half of HMOs), new administrative systems will be required. The cost to those HMOs is expected to add 0.5% to 1.0% of premiums to plan costs. Those figures translate into a best estimate of the average HMO premium increase due to new administrative requirements of 0.25%. Enrollees choosing POS will likely bear the greatest portion of the cost. Data on POS premiums relative to HMO premiums (POS premiums are indicated to be 5% to 10% higher) and an assumed 33% enrollment increase drive additional claims cost estimate of 0.23% of premium. C&L assume that out-of-network services will continue to have higher cost sharing requirements than in-network services and that members who obtain out-of-network benefits will bear those costs. Consequently, out-of-network reimbursement is estimated to have no measurable impact on plan cost.

Congressional Budget Office

The Congressional Budget Office (CBO) prepared a cost estimate of the Patients' Bill of Rights Act of 1998 (PBR). The estimate is based on the introduced bill, the technical changes contained in Senate amendment 3063 introduced on July 7, 1998 (excluding the revenue provisions), and a change in the effective date of section 302(b) to July 1, 1999. The patient protection standards set out in the bill generally apply to group health plans, group health insurance coverage, and individual health insurance coverage. CBO estimates that the PBR would cause premiums to rise by 4.0% in the 10 years following enactment. The impact is "expressed as the expected ultimate percentage change in average health insurance premiums—that is, the change when all of the bill's provisions are fully phased in."

The report, *Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Rights Act of 1998* (July 16, 1998), contains estimates of the impact on premiums for employer-sponsored health plans of seven major provisions in the PBR covering 30 sections of the bill. The provisions, the corresponding sections of the PBR, and their estimated increase in premiums are shown in Exhibit 8.

The CBO report states that because of the extent and complexity of the changes to the health insurance system resulting from the provisions in the PBR, the estimates of their effects are subject to more than the usual amount of uncertainty. To derive the estimates, CBO consulted with a variety of experts, including representatives of managed care plans, health insurers, providers, and private industry; state regulators; practicing and academic health and ERISA lawyers; and health policy researchers. The report warns, however, that in some areas, only limited data are available to determine a cost estimate.

For several of the provisions in the PBR the report discusses potential (qualitative) sources of cost increases, but contains no methodology or empirical evidence for constructing the actual impact estimate. The report also indicates that the cost impacts may differ

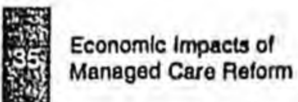
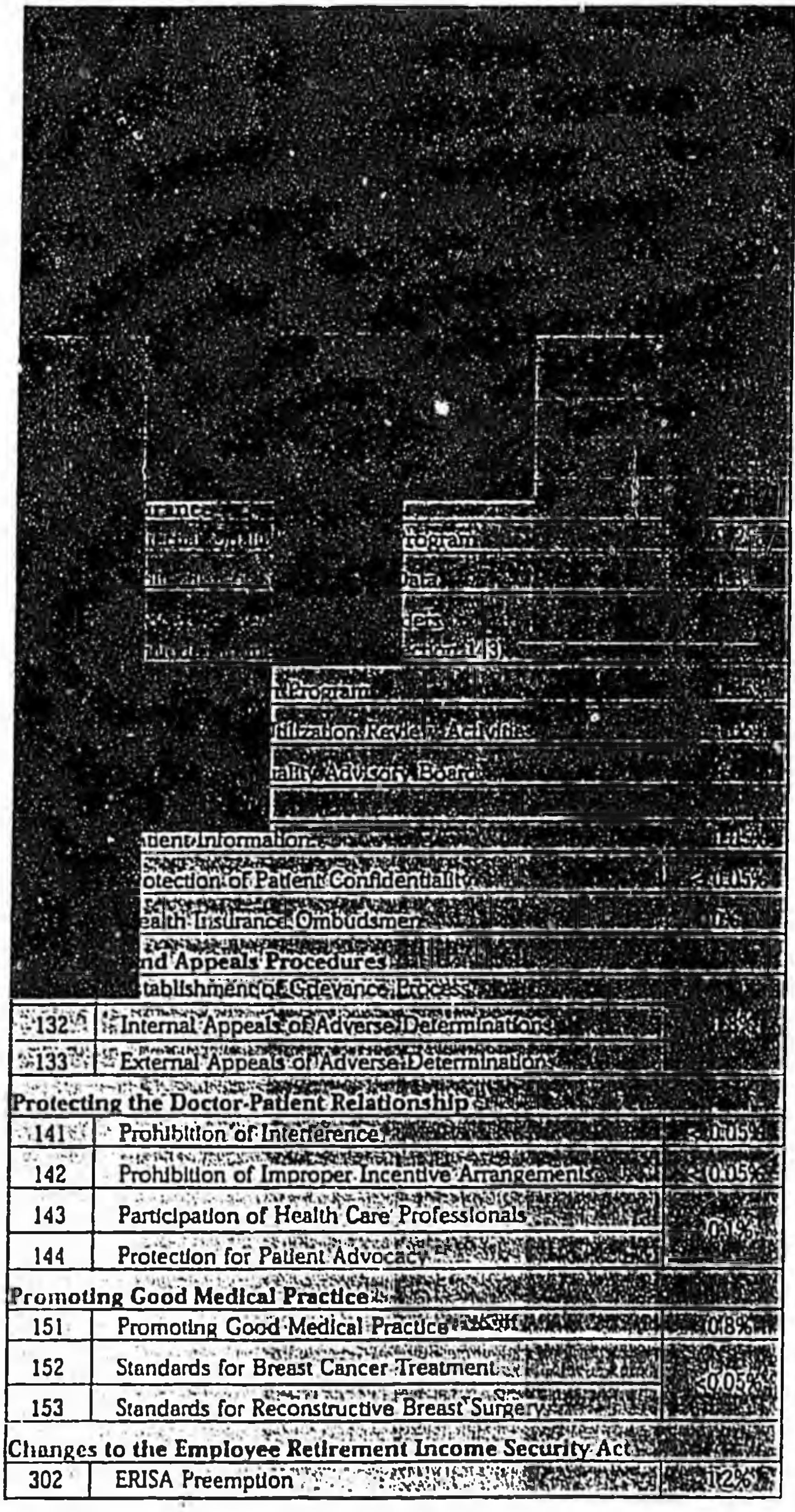


Exhibit 8
Congressional Budget Office
Patients' Bill of Rights Act of 1998



Section	Provision	Estimate
[illegible]	[illegible]Program[illegible]	[illegible]
[illegible]	[illegible]tilization Review Activities	[illegible]
[illegible]	[illegible]ality Advisory Board	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]tient Information	[illegible]
[illegible]	[illegible]otection of Patient Confidentiality	<0.05%
[illegible]	[illegible]ealth Insurance Ombudsmen	[illegible]
[illegible]nd Appeals Procedures		
[illegible]	[illegible]tablishment of Grievance Process	[illegible]
132	Internal Appeals of Adverse Determinations	1.8%
133	External Appeals of Adverse Determinations	
Protecting the Doctor-Patient Relationship		
141	Prohibition of Interference	<0.05%
142	Prohibition of Improper Incentive Arrangements	<0.05%
143	Participation of Health Care Professionals	0.1%
144	Protection for Patient Advocacy	
Promoting Good Medical Practice		
151	Promoting Good Medical Practice	0.8%
152	Standards for Breast Cancer Treatment	<0.05%
153	Standards for Reconstructive Breast Surgery	
Changes to the Employee Retirement Income Security Act		
302	ERISA Preemption	[illegible]

among traditional indemnity plans, indemnity plans with utilization review components, PPOs, IPAs and group- or staff-model HMOs.

Of the 30 provisions in the PBR for which CBO estimated premium impact., eight are estimated to increase premiums at least 0.2%, and of those, three are estimated to increase premiums 0.4% or more. The provisions in the PBR indicated to have the largest estimated effects on premiums are discussed in detail in the next section of this report.

The **access to emergency care** component of the PBR would require plans to pay for emergency care in any licensed hospital emergency department if the condition is serious enough to meet the "prudent layperson" standard. The bill also requires plans to pay for post-stabilization care rendered at nonparticipating institutions. Provisions requiring payments for care provided beyond the initial cost of emergency care, and for emergency care provided in any licensed hospital emergency department generally have not been part of other proposed legislation. For example, neither CBRR nor PARCA extends plans' responsibility to the coverage of ongoing treatment in an emergency facility. Consequently, other premium impact estimates of access to emergency care provisions typically have not included the costs of those requirements.

CBO assumes "that roughly half of current denials of payment for emergency room visits would meet the prudent layperson standard." The number of denials CBO used in deriving their estimate is not presented in the report. The cost estimate is also based on the assumption that payments for treating patients in nonparticipating emergency departments would be 50% higher than payments in participating hospitals. This would represent a 33% discount from out-of-plan hospital emergency departments. There is no available evidence of discounts of this magnitude.

CBO also assumes that once the prudent layperson standard became widely understood, emergency visits and the use of nonparticipating hospital emergency departments would rise, and hospitals would be encouraged to raise their charges for emergency departments. These incentives would at least be partially offset by the increase in plans' incentives to encourage and educate members to seek care in non-emergency department settings, and to provide adequate access to in-plan emergency and ambulatory care. There are generally no documented measures of the proportion of plans, accompanied with the number of

enrollees in those plans, which would comply with these provisions.

The **continuity of care** provisions in the PBR require health plans to notify enrollees on a timely basis of the termination of provider contracts, and permit the individual to continue or be covered with respect to the course of treatment with the provider during a transitional period, generally of 90 days, except for pregnant or terminally ill patients. Termination includes the expiration or nonrenewal of the contract. The provider would agree to accept reimbursement from the plan or issuer and individual involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full.

CBO argues that the major cost of this provision would be the cost of developing systems and procedures to notifying enrollees of provider contract terminations. Where such systems and procedures are already in place, however, the cost impact may be minimal. The CBO estimates are based on the assumption that plans generally gain or lose fewer than 10% of contracting physicians a year. (Data from the AMA's 1997 SMS survey indicated that in 1995, 6% of physicians were dropped from managed care contracts.)

The provisions for **coverage of clinical trials** would require plans to pay for routine patient care associated with certain clinical trials sponsored by the National Institutes of Health (NIH), Department of Veterans Affairs, Department of Defense, or NIH-sponsored cooperative groups. Trials covered by the provisions are trials for life-threatening or serious illnesses for which no standard treatment is effective. Routine patient costs do not include the cost of the tests or measurements conducted primarily for the purpose of the clinical trial involved. Other proposed managed care reform legislation, and other economic impact estimates of proposed legislation generally do not contain this requirement.

In estimating impact of coverage of clinical trials, CBO assumed that patients in an NIH-sponsored trial generate cost of care 25% higher than the costs of similar patients who do not enter trials. The CBO indicates that the estimate is based on preliminary unpublished results of several small studies that found smaller incremental costs. The CBO expects the cost differential to grow because new trials will involve more expensive therapies and the number of individuals enrolled in clinical trials is predicted to triple over the next 10 years.

The number of patients, the cost of care, and whether or not the provisions of the bill cover the trial are expected to differ among phases of clinical trials. The CBO estimate however, fails to account for the phases of clinical trials, and the share of trials that would be categorized as trials for life-threatening or serious illnesses for which no standard treatment is effective. Phase I trials are considered research and generally are not paid for by insurers. Thus, the provisions in the PBR should result in little if any impact on premiums regarding Phase I trials. In Phase II and Phase III trials patient care and research are carried out jointly. But the Phase III trials which compare new therapies to existing standard treatments may not be covered by the provisions of the PBR.

The cost estimate of implementing an **internal quality assurance program** is based on assumption that all health plans except those that are federally qualified HMOs or currently accredited by the National Committee on Quality Assurance would have to develop a new quality assurance unit, or upgrade an existing one. The report does not indicate the percentage of plans that currently meet these conditions, nor does it indicate the costs of developing or upgrading quality assurance units.

Provisions in the PBR require the **collection and analysis of standardized data** on the utilization of health care services, the demographics of enrollees, disease-specific mortality and (if feasible) morbidity, satisfaction with the plan, health outcomes, and indicators of quality. The impact estimate is based on plans being required to review medical records of 2,000 patients each year. The estimate also takes into account the software development costs resulting from expected changes in the minimal dataset. Development costs and expected cost per record or per site are not presented in the report.

CBO expects the cost of this exercise to be higher for health plans with larger and more diffuse networks. Many health plans may already have information systems in place including the Health Plan Employer Data and Information Set (HEDIS) measures currently required under Medicare contracts, as well as results from consumer access and satisfaction surveys, and general health status surveys. Those plans would incur little additional costs in meeting the requirements of the PBR. Therefore, the CBO estimate that the provision would increase premiums by 0.3% on average may be overstated.

CBO estimates that the provisions **establishing a grievance process**, and **establishing the rights to internal and external appeals of adverse determinations** would jointly raise premiums by 0.3%. Clinical peers who had not previously been involved in the decision under appeal would conduct internal reviews. Only physicians would be considered clinical peers of other physicians. The bill would provide much stronger incentives for internal appeals than the Department of Labor regulations affecting internal claims procedures for ERISA health plans that will be released in response to a Presidential memorandum. Although the rate external appeals is tied to the rate of internal appeals, separate cost estimates for internal and external appeals procedures would provide useful information.

CBO assumes that although most health plans have functioning internal review systems, appeals rate will rise under the PBR because of increased consumer knowledge of the appeals process and the availability of external review. The CBO report cites a study by the General Accounting Office that indicates that data on internal appeals rates are highly unreliable and rates vary widely among HMOs — self-reported appeal rates range from 0.07 to 69.4 per 1,000 enrollees annually, with a median of 3.5. Making an adjustment for appeals related to denials of emergency services, which should be reduced under the "prudent layperson" provisions of the bill, CBO assumed a current average appeal rate of 2.5 per 1,000 enrollees. The report does not detail the adjustment methodology.

Costs per internal appeal are expected to rise due to the clinical peer review requirement and overturning a larger share of appeals in favor of enrollees to avoid cost of external review. For certain appeals, plans might apply less stringent utilization review and reduce the overall expected costs. The costs associated with overturned decisions resulting from appeals, and administrative costs are expected to increase more for health plans and issuers that do not have established systems for internal review of grievances. While the report indicates that this would be a small minority, the proportions of plans currently having and not having grievance processes in place, nor the administrative and other costs associated with having appeals overturned are presented in the CBO report.

A group health plan, and a health insurance issuer offering group health insurance coverage, must also provide for an external

appeals process for appealable decisions if the amount involved exceeds a significant threshold (undefined in the bill), or if the patient's life or health is jeopardized as a consequence of the decision. No information on the number or the share of appeals which meet these conditions is presented, however, even though that data at least partially determine the rate of external appeals.

The report indicates that 16 states require external appeals processes, but few claims reach the external appeals stage. Florida is the only state where the appeals rate is significant, about 1 per 10,000 enrollees. CBO assumes that the PBR would increase external appeals rates in all states, and that the rates would also increase through time — to about 4 per 10,000 enrollees after 5 years — as enrollees became more aware of their rights under this provision. This would represent a four-fold increase over current annual rates of external appeals in Florida, and 40% of the rate in the Medicare program where every denial is subject to appeal, and all denied appeals are automatically referred to external review. This suggests that the CBO cost impact estimate of the provisions establishing the rights to external appeals in the PBR might be overstated.

The provisions in the section **promoting good medical practice** prohibits arbitrary interference with medical practices and establish a right of appeal of plans' decisions. These provisions are expected to generate a higher volume of internal and external reviews and a higher probability of decisions that would be unfavorable to plans. CBO considered plans might avoid appeals under this provision by reducing the frequency with which they challenged physicians' decisions, and the likelihood that plans would adopt defensive UR policies when those costs are lower than the expected costs of the reviews when defending those policies.

The CBO report differentiated between managed indemnity plans (fee-for-service plans with utilization review components or utilization management features), preferred provider organizations, and independent practice associations and group- or staff-model health maintenance organizations in assessing the burden of these provisions. No other cost estimates analyzed include managed fee-for-service plans in the estimates of costs of managed care reform legislation. CBO estimates that these provisions would raise premiums by 0.8%, but provides no quantitative basis for the estimate.

The provisions concerning **expanding legal liability for ERISA**

plans are estimated to increase premiums by 1.4% for ERISA plans, and by 1.2% of the premiums of all employer-sponsored plans. Section 302 of the PBR states that the bill does not authorize (i) any cause of action against an employer or other plan sponsor maintaining the group health plan, or (ii) a right of recovery or indemnity by a person against an employer or other plan sponsor for damages assessed against the person pursuant to a cause of action. This does not preclude any cause of action against an employer or other plan sponsor if (i) such action is based on the employer's or other plan sponsor's exercise of discretionary authority to make a decision on a claim for benefits covered under the plan or health insurance coverage in the case at issue; and (ii) the exercise by such employer or other plan sponsor of such authority resulted in personal injury or wrongful death.

The impact estimates are driven by two assumptions, which CBO states are "estimates," but are unsubstantiated. The first is that health plans' liability costs average about 2% of their premiums (not counting defensive medicine by providers). No plan specific information on liability costs as percent of plan premiums is presented by CBO. Barents Group (1998) presents a figure of 0.5% for liability premium costs based on a small sample of insurers, but uses 2.0% as their high end estimate baseline which reflects the cost liability premiums to providers. The Barents Group cost estimate of expanded liability is generally recognized as being biased upward because of the failure to account for the ability of managed care organizations to insure against malpractice liability at significantly reduced rates relative to providers. It follows that the CBO estimates represent a high-end estimate. The second CBO assumption driving their cost estimates is that ending the ERISA preemption increase liability costs by 60% to 75%, in the case of PPOs, POS plans, and HMOs, and by a lesser percentage in the case of indemnity plans.

CBO indicates the premium increase from expanding legal liability for ERISA plans is determined by two primary sources. More than half of the increase comes about from potential suits associated with decisions on medical necessity and coverage, and unintended lawsuits involving providers and plan fiduciaries. Most of the remainder would result from more medical negligence suits against plans, reflecting the financial resources of plans and the effects of the new legal environment. No data are presented, however, to substantiate the number of additional suits or the size of the awards health plans might expect to experience due to the provisions in the PBR.

William M. Mercer

William M. Mercer, Incorporated (Mercer) was commissioned by the American Medical Association to develop an actuarial model to assess the cost impact of **managed care accountability** legislation. The report, *Malpractice Liability Assessment Model: Estimates of the Cost Impact of Managed Care Accountability Legislation* (August 1, 1998), presents impact estimates based on expected medical services distributions by physician subspecialty for various types of managed care organizations (MCOs), and expected MCO malpractice claim incidence and average cost of malpractice claims.

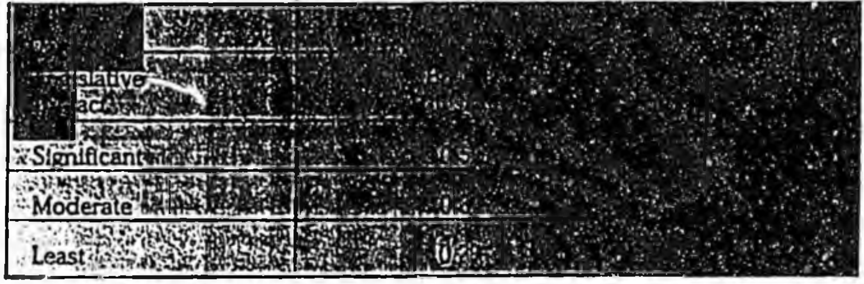
The Mercer analysis derives estimates of increases in health insurance premiums from model managed care accountability legislation which contains the following three components:

- A direct cause of action against health insurance carriers, HMOs, and managed care entities for damages caused by their failure to exercise ordinary care in making health care treatment decisions;
- A prohibition on hold harmless and indemnification clauses in provider contracts; and
- A prohibition on the use of the corporate practice of medicine defense.

The estimates also take into consideration three levels of legislative impact related to existing differences across states in use of the corporate practice of medicine defense; two constructions of ERISA preemption to capture the extent to which the actions brought by enrollees of ERISA plans could be preempted by ERISA; alternative enrollment mixes; and three types of caps on malpractice awards to account for different state tort reform laws. After considering a broad range of impact scenarios, Mercer estimates that managed care accountability legislation would increase premiums between 0.1% to 1.8%.

Exhibit 9 shows estimates for the three levels of legislative impact for broad and narrow ERISA construction presented in the Mercer report.

Exhibit 9
William M. Mercer
Increase as a Percent of MCO Premium, No Cap on Awards



[illegible]	[illegible]
Significant	[illegible]
Moderate	[illegible]
Least	[illegible]

The actuarial model was constructed using a general logic flow that begins with a population enrolled in an IPA or network model HMO that contracts with physicians or physician networks. The enrollment is distributed among commercial, Medicare and Medicaid managed care programs. Mercer cost models produce medical service projections by physician subspecialties. Managed care organization (MCO) malpractice claim incidence is derived from the MCO medical services by physician subspecialty. Applying an average MCO malpractice award and legal expense to the malpractice claim incidence yields the change in MCO cost per member per month.

Under the managed care accountability provisions, an MCO is liable for damages caused to an enrollee by the MCO's failure to exercise ordinary care in making health care treatment decisions. Health care treatment decisions are defined as a determination made when medical services are provided by the plan and a decision that affects the quality of the diagnosis, care or treatment provided to the enrollees. As in other negligence actions, a plaintiff must demonstrate that the MCO breached its duty to exercise ordinary care, and that such breach was the proximate cause of the plaintiff's injury. The provisions also allow for a vicarious liability cause of action, under which an MCO is liable for damages caused by the health care treatment decisions made by its employees, agents, and representatives.

The legislative impact scenarios are designed to reflect the impact of the prohibition of the corporate practice of medicine defense. States are assumed to generally fall within one of three scenarios

with respect to how the corporate practice of medicine doctrine is enforced as follows:

- The state actively enforces a complete bar against the corporate practice of medicine.

- The state actively enforces a bar against the corporate practice of medicine, but exempts from the bar certain providers, such as hospitals, HMOs, and professional corporations.

- The state has no bar against the corporate practice of medicine or has a bar that is not enforced.

The constructions of the ERISA preemption defense allow for two possible impacts. If ERISA preemption is narrowly construed to allow vicarious liability and direct negligence actions against MCOs by ERISA enrollees, the MCO liability exposure from ERISA enrollees is expanded. Alternatively, if the ERISA preemption is broadly construed, the MCO liability exposure from ERISA enrollees remains limited. The estimates are based on the assumption that 90% of the MCO enrollees are covered under an ERISA employee benefit plan. This percentage varies significantly for different states. Thus, the extent to which ERISA enrollees may bring a state law cause of action against MCOs will have a significant impact on estimates.

To account for the different mix of plan types found across the states alternative types of MCOs are considered. Managed care accountability legislation is expected to have the least impact on staff model HMOs, because they have already been subject to vicarious liability malpractice claims, based on their direct employment of physicians. IPA/network model HMOs (which include risk-bearing PPOs) are expected to experience a greater impact. It is assumed that a staff model HMO will incur 30% of the additional liability incurred by IPA/network model HMOs. The estimates are based on an enrollment mix of 96% in IPA/network model HMOs and 4% in staff model HMOs. The estimates are based on an enrollment mix by payer 90% commercial, 5% Medicaid and 5% Medicare. Mercer claim cost models are used to construct medical services distributions by physician subspecialty for each of these populations.

Three types of caps on malpractice awards are incorporated in the Mercer analysis to account for different state tort reform laws. Impact estimates are presented for (i) no cap, (ii) a cap of $250,000 on non-economic damages with no cap on economic or punitive damages, and (iii) a cap of $500,000 on non-economic damages with no cap on economic or punitive damages.

The share of a physician's practice dedicated to providing health services to MCO members are constructed for each of the three categories of enrollees. Another adjustment is made to assign hospital malpractice claims to MCO members. The estimated ratio of the total physician and hospital malpractice claims to physician malpractice claims is 1.14. Applying this factor to the annual incidence of physician malpractice claims per 1,000 members produces an estimate of the incidence of claims that includes both physician and hospital malpractice claims.

The authors of the Mercer study assume that existing claims against physicians and hospitals will remain the same. Given the relationship between existing bars to the corporate practice of medicine and the incidence of vicarious liability claims against MCOs, additional vicarious liability claims are assumed to vary with the legislative impact — 5% for low impact, 10% for moderate impact, and 20% for significant impact. Direct negligence claims are assumed to rise by 10% for all legislative impact scenarios

The average cost of an MCO malpractice claim was derived from statistics in "Civil Jury Cases and Verdicts in Large Counties," Bureau of Justice Statistics, July 1995. The malpractice awards data from the Bureau of Justice Statistics, for plaintiff awards, indicated that the median award was $201,000, the average awards was $1,484,000, 47.1% of awards were over $250,000 and the 24.8% of awards for over $1,000,000. The awards distribution was adjusted for the inclusion of hospital awards, the influence of damage caps, the recent increasing number of awards over $1 million, and the expectation that MCOs will be subject to higher malpractice awards than physicians. Because the awards distributions are based only on plaintiff awards, the average award is also adjusted to reflect the assumption that plaintiffs are successful in 25% of the cases. Average cost per MCO award is estimated to be $429,651, plus legal expenses assumed to average $125,000 over all suits.

Exhibit 10
Summary Comparison of Managed Care Legislation Costs a/

Proposals	Barents for AAHP	Muse & Associates for PARC Alliance	Milliman & Robertson for Walmart	Lewin for President's Commission	Price Waterhouse for Kaiser Family Foundation	Coopers & Lybrand for Kaiser Family Foundation	CBO	Mercer
Expanded Liability	4%-5% (among IPAs, PPOs, and POS plans) 2.7%-8.6%b/		0.0%-0.2%		0.1% to 0.4% (among IPAs)	uncertain	1.2%	0.5%-1.8%
Establishment and Maintenance of Health Care Provider Networks/ Due Process Provisions	5%-8% (depending on plan type)	less than 0.05%-0.1%						
Restrictions on Utilization Review	3%-5% (among HMOs)						0.1%	
Deeming Utilization Review to be Part of Practices of Medicine	2.2%-6.9%b/							
Prohibition of Physician Incentive Payments/No Inducement to Reduce Services (among HMOs)	3%-5%	0.0%	9.5%				less than 0.05%	
Freedom of Choice Acts	9%-16% (depending on plan type)							

Elimination of Prior Authorization for Specialty Referrals/Direct Access within Network	9%	0.0%-0.2%	0.2%				
Medical Necessity Determination	4.1%-6.1%[v]						
Continuity of Care		minimal increase					0.2%
Mandatory Point-of-Service Option	4%-11% (among closed panel plans)	0.3%	0.3%			0.48% (assumes plan members incur higher cost sharing out of network)	0.1%
Any Willing Provider		6.6%-8.6%[v]					
Equivalent Reimbursement Rates In and Out of Network		less than 0.5%	5.5%				
Provision of Emergency Room and Urgent Care Services with Limits on Prior Authorization	1%-3% (among managed care plans)	less than 0.05%	0.5%		less than 1%	0.11%	0.2%
Administrative Requirements			2.0%				
Elimination of Limits on Certain Benefits			5.5%				
Adverse Selection Against Rate Increases	0.1% to 0.5%	4.5%					
Access to Specialists and Standing Referrals to Specialists					0.35% choice of (OBGYNs as primary care providers)	0.02%	0.1%

Exhibit 10 (continued)
Summary Comparison of Managed Care Legislation Costs[a]

Proposals	Barents for AAHP	Muse & Associates for PARC Alliance	Milliman & Robertson for Walmart	Lewin for President's Commission	Price Waterhouse for Kaiser Family Foundation	Coopers & Lybrand for Kaiser Family Foundation	CBO	Mercer
Minimum Stays for Mastectomies					0.01% (48-hour stays)		less than 0.05%	
Expanding Drug Formularies					less than 0.6% (among HMOs)		less than 0.05%	
External Appeals				less than 0.05% (excludes administrative costs)		0.08% (includes administrative costs charged back to plans)	0.3%	
Information Reporting & Disclosure		0.3%-1.3%		0.3%-1.3%		.08%-.4% (under PARCA and CBRR, respectively)	0.3%	

Sources: Barents Group, LLC, *The Effects of Legislation Affecting Managed Care on Health Plan Costs*, (May 1997); Barents Group, LLC, *Impact of Legislation Affecting Managed Care Consumers: 1999- 2003*, (April 1998); Muse & Associates, *The Health Premium Impact of H. R. 1415/S.644, the Patient Access to Responsible Care Act (PARCA)*, (January 1998); Milliman & Robertson, Inc., *Actuarial Analysis of the Patient Access to Responsible Care Act (PARCA)*, (November 1997); The Lewin Group, *Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals*, (November 1997); Price Waterhouse, *The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals in California*, (November 1997); Coopers & Lybrand, LLP, *Estimated Costs of Selected Consumer Protection Proposals*, (April 1998); Congressional Budget Office, *Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Rights Act of 1998*, (July 1998); and William M. Mercer, Inc. and the American Medical Association, *Malpractice Liability Assessment Model: Estimates of the Cost Impact of Managed Care Accountability Legislation* (August 1998).

a/ Estimates of increased costs or reductions in savings rather than premium increases have been specified.
b/ Figures from Barents (1998), all other figures in the column are from Barents (1997).

References

Barents Group, LLC. Impact of Legislation Affecting Managed Care Consumers: 1999-2003. (Washington DC: Barents Group, LLC), April 1998.

Barents Group, LLC. The Effects of Legislation Affecting Managed Care on Health Plan Costs. (Washington DC: Barents Group, LLC), May 5, 1997

Chassin, Mark R., et al. "Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? A Study of Three Procedures," Journal of the American Medical Association. November 12, 1987.

Congressional Budget Office. Cost Estimate, H.R. 3605/S. 1890, Patients' Bill of Rights Act of 1998. July 16, 1998.

Congressional Budget Office. Predicting How Changes in Medicare's Payment Rates Would Affect Risk-Sector Enrollment and Costs. March 1997.

Congressional Budget Office. CBO's Estimates of the Impact on Employers of the Mental Health Parity Amendment in H.R. 3103. May 1996.

Congressional Budget Office. The Effects of Managed Care and Managed Competition. February 1995.

Congressional Budget Office. Effects of Managed Care: An Update. March 1994.

Coopers & Lybrand, LLP. Estimated Costs of Selected Consumer Protection Proposals. (San Francisco: Coopers & Lybrand, LLP), April 1998.

Emmons, David W. The Impact of Managed Care on National Health Spending: A Critical Review of the Literature. Discussion Paper 95-2, Center for Health Policy Research, American Medical Association, June 1995.

Emmons, David W. and Gregory D. Wozniak. "Physicians' Contractual Arrangements with Managed Care Organizations," Socioeconomic Characteristics of Medical Practice 1997. (Chicago: American Medical Association), 1997.

Greene, Timothy, "Vulnerable Populations and Medicare Managed Care," Report to Congress: Context for a Changing Medicare Program. Medicare Payment Advisory Commission. (Washington, DC: June 1998).

Healthcare Trends Report. Volume 11, No. 1, January 1997.

Kessler, D. and M. McClellan, "Do Doctors Practice Defensive Medicine?" Quarterly Journal of Economics. May 1996.

Lewin Group. Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals. Presidential Advisory Commission on Consumer Protection and Quality in Health Care Industry, Final Report, November 1997.

Lewin-ICF. Estimating the Costs of Defensive Medicine. October 21, 1992.

William M. Mercer, Inc. and the American Medical Association. Malpractice Liability Assessment Model: Estimates of the Cost Impact of Managed Care Accountability Legislation. August 1, 1998.

Milliman and Robertson, Inc. Actuarial Analysis of the Patient Access to Responsible Care Act (PARCA). November 7, 1997.

Muse & Associates. The Health Premium Impact of HR. 1415/S. 644, the Patient Access to Responsible Care Act (PARCA). (Washington DC: Muse & Associates), January 28, 1998.

Norwood, Charles. Cost Study of PARCA. http://www.house.gov/norwood/Cost.html, February 28, 1998.

Physician Payment Review Commission. Monitoring Access and Financial Liability for Medicare Beneficiaries. Annual Report to Congress, 1996. 1996.

Policy Research Perspectives. "The Medicare-to-Private Payment Gap: Is Medicare the "High" Payer?" (Chicago: American Medical Association), November 1996.

Price Waterhouse LLP. The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals From California. November 1997.

Stapleton, David C. New Evidence of Savings from Network Models of Managed Care. (Washington DC: Lewin-VHI), May 1994.

Wozniak, Gregory. Review of Milliman & Robertson Analysis of the Patient Access to Responsible Care Act of 1997. (Chicago: American Medical Association), February 1998.

Wyatt Company. Cost Analysis of State Legislative Mandates on Six Health Care Practices. 1991.

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 16, 1999

S. 6
Patients' Bill of Rights Act of 1999

As modified by the sponsors

SUMMARY

The Patients' Bill of Rights Act of 1999 would impose new requirements on the structure and operation of group health plans and health insurance issuers and would provide members of health plans and insured individuals with new rights to obtain certain health care services. It would require both internal and external review processes for members to appeal decisions by health plans and insurers. It would also amend the Employee Retirement Income Security Act (ERISA) to allow individuals to sue health plans and insurers for personal injury or wrongful death under state tort laws. These provisions would have a significant effect on the costs of private insurance as well as the federal budget. Because of the extent and complexity of the changes to the health insurance system that could result from such provisions, estimates of their effects are subject to more than the usual amount of uncertainty.

The bill would affect the federal budget in three ways. First, by increasing premiums for employer-sponsored health benefits, it would substitute nontaxable employer-paid premiums for taxable wages and would therefore decrease federal income and payroll tax revenues. The Congressional Budget Office (CBO) estimates that the proposal would reduce federal tax revenues by $390 million in 2000 and by $7.0 billion over the 2000-2004 period. Second, the bill would impose additional costs on the Federal Employees' Health Benefits Program, most of whose plans are classed as health insurance issuers. CBO estimates that these costs would amount to $240 million over the 2000-2004 period, of which $95 million would be mandatory. Third, it would require additional spending for administration and regulatory activities, subject to appropriation of the necessary amounts. These discretionary costs would total an estimated $315 million over the next five years. CBO recognizes that this bill could affect practice styles in fee-for-service settings, potentially raising fee-for-service expenditures under Medicare. CBO has not estimated the magnitude of such an effect.

The bill's requirements on group health plans offered by state, local, and tribal governments would be optional under the Public Health Service Act (PHSA). Consequently, those requirements would not be intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA).

The bill would establish several private-sector mandates as defined by UMRA. Provisions imposing new functions and operating practices on private insurers and health plans would create private-sector mandates. Provisions that would indirectly raise plan costs, such as those giving plan members the right to sue plans for personal injury, would not be considered private-sector mandates. The estimated costs of the private-sector mandates would greatly exceed the annual threshold established in UMRA ($100 million in 1996, adjusted for inflation) in each of the years after enactment. CBO estimates that the cost of private-sector mandates would total about $41 billion over the 2000-2004 period.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of the bill is shown in Table 1. The costs of this legislation fall within budget function 500 (health) and other functions.

TABLE 1.
ESTIMATED BUDGETARY EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
REVENUES										
Income and HI Payroll Taxes	-270	-680	-1,070	-1,320	-1,530	-1,660	-1,750	-1,850	-1,950	-2,060
Social Security Payroll Taxes	-120	-300	-470	-580	-680	-730	-770	-820	-860	-910
Total	-390	-980	-1,540	-1,900	-2,210	-2,390	-2,520	-2,670	-2,810	-2,970
DIRECT SPENDING										
FEHBP--Annuitants	5	10	20	25	35	40	45	45	50	55
AUTHORIZATIONS OF APPROPRIATIONS										
FEHBP--Active Workers	5	15	30	40	55	60	65	70	75	75
Federal Administrative Costs	25	70	70	75	75	75	80	80	80	85
Total	30	85	100	115	130	135	145	150	155	160

SOURCES: Congressional Budget Office and Joint Committee on Taxation.

NOTES: HI = Hospital Insurance; FEHBP = Federal Employees Health Benefits Program

BASIS OF ESTIMATE

The bill would significantly change the relationships between employers, health plans, health insurers, providers, and patients. These changes would be complex and would be imposed on a rapidly evolving health care system. In some areas, limited data on which to base a cost estimate are available. CBO has consulted with a variety of experts, including representatives of managed care plans, health insurers, providers, and private industry; state regulators; practicing and academic health and ERISA lawyers; and

health policy researchers. Although this cost estimate is subject to more than the usual amount of uncertainty, it represents CBO's best judgment about the likely effects of the bill. The ultimate costs could be substantially larger or smaller.

CBO estimated the impact of each provision on health plan premiums in the 10 years following enactment (which is assumed to occur by October 1, 1999). This cost impact is expressed as the expected ultimate percentage change in average health insurance premiums--that is, the change when all of the bill's provisions are fully phased in. Most of the provisions would reach their full effect within the first 3 years after enactment. CBO estimates that premiums for employer-sponsored health plans would rise by an average of 4.8 percent in the absence of any compensating changes on the part of employers. Table 2 shows the estimated effect of each provision on premiums, before employers modify their behavior to offset some of the increase. The effects are expressed as a percentage of total premiums for all nonfederal employer-sponsored plans, including plans that would face no increase in costs.[(1)]

TABLE 2.
ESTIMATED ULTIMATE EFFECT OF THE PATIENTS' BILL OF RIGHTS ACT ON PREMIUMS FOR EMPLOYER-SPONSORED HEALTH INSURANCE (In percent)

Provision	Increase in Premiums
Section 101--Access to Emergency Care	0.4
Section 102--Offering of Choice of Coverage Options	0.2
Section 103--Choice of Providers	a
Section 104(a)--Obstetrical and Gynecological Care	0.1
Section 104(b)--Specialty Care	a
Section 105--Continuity of Care	0.2
Section 106--Coverage for Clinical Trials	0.5
Section 107--Access to Needed Prescription Drugs	b
Section 108--Adequacy of Provider Network	0.2
Section 109--Nondiscrimination in Delivery of Services	0.1
Section 111--Internal Quality Assurance Program	0.2
Section 112--Collection of Standardized Data	0.2
Section 113--Process for Selection of Providers	b
Section 114--Drug Utilization Program	b
Section 115--Standards for Utilization Review Activities	b
Section 116--Health Care Quality Advisory Board	0
Section 121--Patient Information	b
Section 122--Protection of Patient Confidentiality	b
Section 123--Health Insurance Ombudsmen	0
Section 131--Establishment of Grievance Process	0.3
Section 132--Internal Appeals of Adverse Determinations	c
Section 133--External Appeals of Adverse Determinations	c
Section 141--Prohibition of Interference	b
Section 142--Prohibition of Improper Incentive Arrangements	b
Section 143--Participation of Health Care Professionals	0.2

Section 144--Protection for Patient Advocacy	d
Section 151--Promoting Good Medical Practice	0.8
Section 152--Standards for Breast Cancer Treatment	b
Section 302--ERISA Preemption	1.4
Total	4.8

a. Included in estimate of section 108.

b. Less than 0.05 percent.

c. Included in estimate of section 131.

d. Included in estimate of section 143.

Employers could respond to premium increases in a variety of ways to reduce their impact. They could drop health insurance entirely, reduce the generosity of the benefit package, increase cost-sharing by beneficiaries, or increase the employees's share of the premium.

CBO assumed that employers would deflect about 60 percent of the increase in premiums through these strategies. The remaining increase in premiums would be passed on to workers in the form of lower wages. These lower wages would reduce federal receipts from income and payroll taxes.

The bill would somewhat reduce the ability of managed care organizations to limit the use of health care services. The loosening of styles of practice by providers in managed care plans could spill over to other settings, raising costs to some degree in fee-for-service plans and potentially raising fee-for-service expenditures under Medicare. That conclusion is based on recent studies that found lower fee-for-service expenditures under Medicare in areas of the country with greater market penetration by HMOs. Those results suggest that providers who participate in managed care plans change their practice styles for all of their patients, not just for those enrolled in HMOs. Decreasing the restrictiveness of managed care plans could, as a result, lead to higher costs in fee-for-service plans as well. CBO has not estimated the magnitude of such an effect for either Medicare or private insurance.

Title I of the bill, comprising seven subtitles, would establish standards to protect consumers and providers in managed care plans and other health insurance plans. Title II would apply the standards to group health plans and issuers of individual health insurance coverage as defined in title XXVII of the Public Health Service Act. Title III would apply the standards to group health plans and group health insurance coverage under the Employee Retirement Income Security Act. Title IV would apply the standards to group health plans under the Internal Revenue Code. In this estimate, the costs of the patient-protection standards are assigned to the corresponding sections of title I.

In addition, title III would amend ERISA to allow enrollees in employer-sponsored health insurance plans to sue their plans under state law for damages resulting from personal injury or wrongful death. It would also require the Secretary of Labor to investigate complaints of discrimination or retaliation against health care professionals. The incremental costs of these provisions are shown separately.

Access to Care

Subtitle A would impose requirements on the structure of health plans and the access to services and providers they offer their members. These requirements would affect access to emergency and specialty care, coverage of clinical trials, and adequacy of provider networks.

Section 101–Access to Emergency Care. This section would require plans to pay for emergency care received without prior authorization in any licensed hospital emergency department when the condition is serious enough to meet the "prudent layperson" standard (as applicable to Medicare+Choice plans). Moreover, the plan could charge the patient no more than if the emergency department were in the plan's network. CBO assumes, therefore, that the plan would be responsible for paying the non-participating provider's full charge for emergency services rendered. Finally, the plan would be required to pay for post-stabilization care rendered at the nonparticipating institution consistent with regulations governing Medicare and Medicaid.

Many states have laws in place that require that health plans pay for emergency services; those laws vary widely in their definitions of emergencies and requirements for out-of-network coverage. CBO estimates that about 20 percent of the U.S. population lives in states whose laws fully meet the standard of this section and another 60 percent of the population resides in states with laws that partially conform. CBO assumed that roughly half of current denials of payment for emergency room visits would meet the prudent layperson standard and that the costs to health plans of treating patients in nonparticipating emergency departments would be 50 percent higher than they would be in participating hospitals. Once the prudent layperson standard became widely understood, members of plans would increase emergency visits and probably their use of nonparticipating hospital emergency departments. The return to fee-for-service insurance payment to nonparticipating providers would encourage hospitals to raise their charges for visits to emergency departments. CBO estimates that the new prudent layperson standard, the removal of restrictions on nonparticipating providers' payment rates, and the inducement of additional visits to emergency rooms would increase the average premium by 0.4 percent across all private employer-sponsored health plans.

Section 102–Offering of Choice of Coverage Options. This section would require health plan sponsors to offer point-of-service (POS) plans whenever their existing offerings of plans did not include a plan that pays for care received from non-network providers. CBO estimates that about 23 percent of employees currently work in organizations offering employee health plans that limit choice of provider and do not offer an alternative plan without such limits. The provision would increase the administrative cost of processing out-of-plan claims and increase the use of services by those who selected the POS option. Because the provision would not impose any requirements on the financial terms of the POS option, employers could offset some of its costs by increasing the cost-sharing requirements for beneficiaries. Based on out-of-plan use in existing preferred provider organization (PPO) and POS plans, CBO estimated that 10 percent of employees in firms newly offering the POS option would select it and that the net costs (benefit payments and administrative expenses) for those individuals would increase by 11 percent. The net effect averaged across all employer-sponsored health plans would be an increase of 0.2 percent in premiums.

Section 103–Choice of Providers. This section would require health plans to allow enrollees to choose among the participating health care providers who are available to accept patients, but it would allow health plans to restrict choice among specialists if the plan clearly informed participants of these limitations. Alone, this section would have negligible effects on health care costs because it would give plans the right to close physician practices to new patients and would also allow plans to write rules into their description of benefits that detailed limitations on access to specialists. However, this provision would be appealable under sections 132 and 133 and could interact with section 108 (requiring an adequate provider network) as it was considered by appeals bodies. For example, if only one physician in a specific subspeciaity was available to see patients at the time of referral, patients might argue on the basis of both this section and section 108 that the plan was not providing a sufficient choice of providers. Because of the interaction of this section with section 108, CBO includes the cost of this section in its estimate of section 108.

Section 104(a)–Obstetrical and Gynecological Care. This subsection would grant women specific rights to designate a participating obstetrical and gynecological specialist as their primary care provider and to receive covered preventive women's health and pregnancy services from a participating obstetrical and gynecological specialist.

This provision would require an immediate change in the design and operation of some plans, but it would not affect all types of plans. Fee-for-service and PPO plans do not require referrals to specialists. In addition, fully-insured ERISA plans and self-purchased insurance products are subject to state mandates on access to obstetrical and gynecological specialists; these mandates already exist in states containing almost 70 percent of the population. CBO estimates that about 20 percent of individuals in employer-sponsored plans would be newly affected by section 104(a) to a substantial extent. CBO relied on an estimate of the effect of this provision in California made by Price Waterhouse for the Kaiser Family Foundation which found that such plans could see a 1 percent increase in physician costs or a 0.35 percent increase in overall costs.[(2)] Thus, across all employer-sponsored plans, section 104(a) would raise employer-sponsored premiums by about 0.1 percent.

Section 104(b)–Specialty Care. Section 104(b) would require plans to pay for referrals to specialists when such care is justified by the complexity or seriousness of the condition and the plan provides benefits for such treatment. If the referral were made to an out-of-network specialist, the patient could be charged no more than if the provider were participating in the network. The provision would also require a plan to establish a procedure for designating a specialist as the primary care provider when the plan is organized on a gatekeeper model and when the patient has a condition justifying coordination of care by a specialist. The plan would also have to establish a procedure for allowing standing referrals to a specialist when it was appropriate. Disputes arising out of this provision would be appealable under sections 132 and 133.

Although the provision does not explicitly specify that a plan would be required to refer a patient to a nonparticipating specialist, the provision would give appeal agencies the power to decide whether participating specialists had adequate expertise to treat the condition. Thus, this provision would stimulate appeals of plan decisions regarding virtually all aspects of referral management. Consequently, it would reduce the power of health plans in contract negotiations with specialists, especially sub-specialists concentrating on specific diseases or conditions. Patients and referring physicians could argue in the appeals process that certain centers of excellence or sub-specialists were uniquely qualified to treat unusual conditions. As these providers came to recognize the potential loss of plans' power to steer patients to designated specialists, they could become less willing to make fee concessions as a condition of joining the plan's network. These effects would be felt most heavily by the plans that rely heavily on provider discounts to achieve savings.

Plans would also have to establish new policies and procedures for dealing with requests for redesignation of specialists as primary care physicians in certain cases and for standing referrals. The setup and maintenance of such procedures would involve minor additional administrative costs. However, to the extent that patients with chronic conditions were assigned to specialists for primary care, the plan's pricing power with its other primary care providers could be reduced. Like section 103, this subsection would interact with section 108, which requires an adequate provider network. Therefore, CBO includes its cost in the estimate of section 108.

Section 105–Continuity of Care. This section would add about 0.2 percent to the average premium. During a transitional period, it would require employee health plans to pay for care delivered by a nonparticipating provider when the plan terminates its contract with a provider while a patient is receiving a course of care. The transition period would be 90 days, with a longer period allowed for pregnant or terminally ill patients. The termination could result either from dropping a physician from a plan's network

or from deleting an insurance product from an employer's offerings of health plans. The right to transitional care would require health plans to adopt new systems and procedures for contracting with providers and for handling transitions from one insurance plan to another. These systems would involve a one-time development cost as well as additional ongoing costs.

In the case of terminating a contract with an individual provider, the major cost to a plan would be the cost of notifying enrollees. Health plans generally gain or lose fewer than 10 percent of contracting physicians a year. Notification would involve identifying recent encounters by enrollees with terminated physicians and informing the enrollee of rights to transitional care, if the provider remained willing to accept the terms of the old contract.

In the case of terminating an insurance product, costs would increase not only because enrollees would have to be notified but also because systems and procedures would be required to administer the transition between plans. This system would require insurers to contract with willing out-of-plan providers for a limited period of time and incur costs associated with contract negotiations. The new health plan would be responsible for educating the out-of-plan provider about the plan's policies regarding quality assurance and utilization review. Although these arrangements could increase costs of health insurers and employers, they would also impose a burden on providers. Therefore, the aggregate cost of the claims exceptions process would be largely attenuated by its infrequent use.

Section 106–Coverage of Clinical Trials. This section would require health plans to pay for routine patient care associated with certain clinical trials sponsored by the National Institutes of Health (NIH), Department of Veterans Affairs (VA), Department of Defense (DoD), or NIH-sponsored cooperative groups. Only trials for life-threatening or serious illnesses for which no standard treatment is effective would qualify. The federal government's or cooperative group's contribution could be limited to in-kind contributions. The health plan would be required to pay for care at a rate no higher than it pays to participating providers, and it could require a patient to be treated by a participating provider, if such a provider was collaborating in the trial.

A high but declining portion of trial-related patient care costs is currently paid by private health plans.[3] CBO estimates that health plans currently pay at least 90 percent of these costs. NIH personnel indicated that their supported clinical trials generally cover only the research costs (for example, data collection and statistical analysis) and sometimes the experimental therapy. Medical procedures or services are paid out of the research budget infrequently (for example, when they are performed exclusively to further a research objective and have no diagnostic or therapeutic value to the patient). Private sponsors or in-kind contributions by providers may play some role, but these sources of funding are likely to be small in the aggregate.

NIH-sponsored cooperative groups typically mount studies funded by private entities as well as NIH. For example, cooperative groups sponsored by the National Cancer Institute (NCI) receive funding from NCI to support a research infrastructure and a peer review process as well as for specific NCI-sponsored trials. However, they also conduct studies on behalf of private sponsors. As with NIH-sponsored studies, the private sponsor pays for research costs and often the experimental therapy but typically relies on insurers and health plans to pay for other care provided to participants in the trial.

CBO obtained estimates from NIH, VA, and DoD of the number of individuals who entered their sponsored treatment trials each year. Most of these entrants are under age 65, and most have private insurance. The estimate assumes that virtually all such trials would meet the test of being for serious or life-threatening illness for which no existing therapy is fully effective. The estimate also assumes that the bill would not require health plans to pay for treatments that would not be covered by the plan if they were not experimental.

Because the provision would reduce the cost of clinical trials to governmental and private sponsors, it would be likely to increase the number of patients enrolled in approved trials. At least three responses would occur. First, researchers would expand the size of trials to answer more research questions and to do so with greater precision. Second, more trials would be funded. Third, researchers would seek to test more expensive treatments.

CBO assumed that today each patient in an NIH-sponsored trial has costs of care that are 10 percent higher than the costs of similar patients who do not enter trials. This estimate is based on published and unpublished results of several small studies that compare costs of cancer patients in clinical trials with similar patients who are not in trials. Those studies have found smaller incremental costs, but they did not include the relatively infrequent trials involving highly expensive therapies (such as autologous bone marrow transplantation for breast cancer). The cost differential could be expected to grow in the future as new trials involve more expensive therapies.

CBO further assumed that the provision would triple the number of individuals enrolled in clinical trials gradually over the next 5 years. Although this figure may be an underestimate of the long-term effect, constraints on the availability of trained clinical research personnel would limit the rate of increase in the near term.

The provision would limit the payment that plans would have to make to nonparticipating providers, thereby providing large managed care organizations with some bargaining power over the design and cost of trials. Specifically, plans would be required to pay those providers the rates that they would normally pay to participating providers for "comparable services." But disputes between nonparticipating providers and health plans could arise over the definition of comparable services. Those disputes could lead to suits under ERISA to enjoin violations of this provision. Depending on how the federal courts interpreted the provision, health plans might have little power to negotiate with protocol sponsors over rates of payment.

CBO estimates that this provision would ultimately increase the average premium across all kinds of employer-sponsored health plans by 0.5 percent.

Section 107--Access to Needed Drugs. Section 107(a) would require plans using restrictive drug formularies to have written policies and a process for making exceptions. CBO surveyed the evidence on current pharmaceutical benefits and concluded that virtually all drug formularies already have such processes in place.

Section 107(b) would prohibit a health plan from refusing to cover a drug or device that is approved by the Food and Drug Administration (FDA), when it is prescribed for the approved use, on the grounds that the treatment is experimental. This prohibition could create new administrative costs for health plans that currently rely on investigational technology clauses in their benefit contracts to deny payment for new treatments. These clauses allow plans to avoid conducting case-by-case reviews of medical necessity for some new technologies. CBO assumes that plans would gradually adjust to the new requirement by excluding some specific technologies from covered benefits and by using determinations of medical necessity to limit coverage for others. The additional administrative costs associated with these changes would be small, because few new technologies are excluded as investigational.

CBO estimates that this section would raise health plan costs by less than 0.05 percent.

Section 108--Adequacy of Provider Network. This section would require plans to establish networks that provide adequate and appropriate levels of availability of needed services. It provides little specific language defining what kinds of networks would be considered adequate or appropriate. CBO assumes that

the requirements for consumer choice (section 103) and access to specialists (section 104(b)) would necessitate several participating providers within specialties and subspecialties in order to assure geographic proximity and timely access. Thus, this provision would put pressure on some plans to augment their networks of providers. In conjunction with sections 103 and 104, this section would reduce the pricing power of plans when they negotiated contracts with providers. Depending on how it was interpreted by regulation, the requirement for an adequate network could require plans to become price-takers in areas with few physicians in certain key specialties and in small metropolitan areas or rural areas with few physicians in general. CBO estimates that the net effect of these potential impacts on health plan premiums is 0.2 percent for all employer-sponsored plans.

Section 109--Nondiscrimination in Delivery of Services. This section would prohibit plans from discriminating against health plan members in the delivery of health care services on the basis of race, color, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. Plans would not be prohibited from limiting health insurance coverage on the basis of pre-existing conditions or from charging higher premiums for such coverage. The boundary between a disability and a pre-existing condition is often unclear, however, and plaintiffs could sue under ERISA for injunctive relief on the grounds that determinations by health plans violated this section. CBO estimates that this provision would increase premiums by 0.1 percent.

CBO's estimate assumes that this provision would not prohibit health plans from excluding certain classes of health care services, such as prescription drugs or mental health services, from its contract benefits.

Quality Assurance

Subtitle B lays out a program for assessing and monitoring the care delivered and outcomes of care for plan members. It would require plans to set up an internal quality assurance program to oversee the collection of data on services and outcomes and to correct problems of quality; develop a set of standards and procedures for selecting participating providers, including verification of the provider's background; and, for plans with prescription drug benefits, have a quality improvement program that encourages appropriate use of prescription drugs and reduces the incidence of adverse drug interactions. It would also specify requirements for utilization review (UR), including standards of timeliness and involvement of clinical peers (that is, physicians) in the UR process.

Section 111--Internal Quality Assurance Program. This section would require each health plan or health insurer to maintain a separate office responsible for carrying out the provisions of the subtitle. The program would have a unit director and a written plan for quality assurance, with criteria for plan performance and patient outcomes. It also would have a system to receive reports of quality concerns from providers and enrollees. And, it would have the capability of producing standardized clinical data. Federally qualified health maintenance organizations (HMOs) and plans accredited by a recognized accrediting organization would be deemed to comply with this requirement.

The estimate assumes that all health plans except those that are federally qualified HMOs or currently accredited by the National Committee on Quality Assurance would have to develop a new quality assurance unit (or upgrade an existing one), with a physician director, data analysts, nurse abstracters, and clerical support personnel. CBO estimates that establishing or upgrading these units would increase costs by 0.2 percent across all employer-sponsored plans.

Section 112--Collection of Standardized Data. The bill would require the collection and analysis of standardized data on the utilization of health care services, the demographics of enrollees, disease-specific mortality and (if feasible) morbidity, satisfaction with the plan, health outcomes, and indicators of quality. The exact requirements for data collection and analysis would be specified by the Secretary of Health and

Human Services (HHS), subject to the recommendations of the Health Care Quality Advisory Board. The costs of collecting and analyzing data would depend on the data items selected and required by the Secretary. Because information systems vary widely, the costs of these reporting systems would fall unevenly on different types of plans. Some measures would be harder for tightly managed HMOs to produce, while others would be harder for broad network plans to produce.

Based on trends in data collection and quality measurement under the Medicare program, CBO assumed that the data items required by the Secretary would include all of the Health Plan Employer Data and Information Set (HEDIS) measures currently required under Medicare contracts, plus additional measures required for HEDIS accreditation in 1999, as well as new measures specifically required in the bill, such as disease-specific mortality. The Quality Improvement System for Managed Care proposed by the Health Care Financing Administration (HCFA) for all Medicare+Choice Plans would require them to produce HEDIS measures as well as other quality measures. So far, HCFA has made no separate arrangements for PPOs or other broad network plans, and the estimate assumes that the Secretary would make no special arrangements under this bill for such plans.

Some HEDIS measures could be compiled from administrative data (for example, electronic claims forms), especially if claims forms are altered to capture specific items required under HEDIS. However, most of the HEDIS measures required by Medicare involve reviewing the medical records (or charts) of a sample of beneficiaries--about 400 for each measure. Moreover, the HEDIS manual requires plans to perform chart reviews to verify some measures when administrative data are inadequate. The estimate assumes that data requirements would be expanded gradually to include severity of disease or other risk-adjustment measures that could be measured reliably only through chart reviews.

Medicare's current rules for risk plans require two direct surveys of patients: a survey of consumer access and satisfaction and a survey of general health status. HCFA requires each Medicare plan to survey 1,000 enrollees. The estimate assumes that these surveys would also be required of private insurers, only in larger numbers because of the need to cover all age groups. The need for a survey of health status would be important for adjusting outcomes for differences in risk profiles among plans, so CBO assumes that sooner or later it would be part of the information package.

The estimate takes into account the likelihood that the minimal dataset would change from year to year, requiring continual software development. It also assumes that each health plan would be required to review the medical records of 2,000 patients each year. Some of these records would be in physicians' offices. The cost of this exercise would be higher for health plans with larger and more diffuse networks. CBO estimates that the provision would increase premiums by 0.2 percent on average.

Section 113—Process for Selection of Providers. This section would require plans that selectively contract with health care professionals to develop and maintain a written process governing their selection. The plan would have to verify the provider's professional license and determine whether the license had ever been suspended or revoked. The section would prohibit plans from excluding professionals on the basis of their location in areas with high-risk patients. Plans could not exclude certain kinds of professionals from participating solely on the basis of the class of certification or licensure, as long as the services the individual would deliver were within the scope of his or her license.

This provision would entail administrative costs to verify and update the status of licensure for both potential and currently participating professionals. Most plans already verify the credentials of participating providers, at least initially. In addition, these costs would largely overlap those of section 143 (regarding the participation of health care professionals). Consequently, CBO has included them in the estimate of section 143.

Section 114–Drug Utilization Program. Although the bill would require health insurers to operate a drug utilization review program, pharmacies and pharmaceutical benefits managers are currently providing these services. Thus, the incremental costs associated with drug utilization review would be small.

Section 115–Standards for Utilization Review Activities. This section sets out requirements for the conduct of utilization review activities. It would require plans to specify clinical review criteria developed with input from appropriate physicians and based on outcomes of care to the extent feasible. The requirements of the section are largely consistent with current practice in health plans that rely on utilization review. Therefore, CBO estimates this provision would increase health plan costs by less than 0.05 percent.

Section 116–Health Care Quality Advisory Board. This section would establish an appointed health care quality advisory board to identify, update, and distribute quality measures for health plans; advise the Secretary of HHS on the minimum data set; and advise the Secretary on standardized formats for this information. CBO estimates that the operations of the Heath Care Quality Board would cost $15 million over the 2000-2004 period, assuming appropriation of the necessary amounts.

Patient Information

Subtitle C would require health plans to provide information about policies governing their operations, as well as the quality-assurance data called for in subtitle B. It also requires health plans to protect the confidentiality of individually identifiable information. Finally, it calls for federal grants to states or nonprofit entities for new health insurance ombudsmen, whose job would be to assist consumers in their interactions with group health plans.

Section 121–Patient Information. The section contains a long list of information that plans would be required to provide to enrollees annually or to make available upon request. Much of the required information is typically provided now as part of a plan's handbook or could easily be incorporated into that document. Although a plan's documents would have to be amended to meet the requirements of this provision, such documents are continually updated in any event. The provision of this information as part of the plan document would not appreciably raise health care costs. Although the requirement that the plan provide information on all participating providers (for example, name, address, telephone number, availability, and credentials) might represent a new operation for many plans, the costs of this requirement should also be modest.(4)

Section 122–Protection of Patient Confidentiality. The provision requiring plans to safeguard enrollee information may impose a small additional cost on those employee health plans that do not have formal policies on data confidentiality, but discussions with health insurance and managed care plan executives indicate that the requirements of this provision are general practice in the insurance business today. Moreover, the Health Insurance Portability and Accountability Act of 1996 requires the Secretary of HHS to promulgate regulations by February 2000, protecting the confidentiality of certain patient information (if the Congress fails to enact legislation by August 1999). Thus, this provision would not have a significant effect on premiums.

Section 123–Health Insurance Ombudsmen. This section would authorize the appropriation of such amounts as are necessary to provide grants to states to establish a health insurance ombudsman program. The ombudsman would be directed to assist consumers in choosing health insurance coverage and to help dissatisfied enrollees with appeals and grievances. If a state did not provide an ombudsman, the Secretary of HHS would provide one. CBO estimates that outlays for these grants would total $55 million during the 2000-2004 period.

Grievance and Appeals Procedures

Subtitle D would require all group health plans and health insurance issuers to establish a system for handling enrollees' grievances, which would include a two-tier process for reviewing appeals of plans' decisions. The first stage would involve appeals to professionals within the plan. Enrollees who were not satisfied with that internal decision could then appeal certain grievances to an external appeals board.

CBO estimates that these provisions, which are highly interrelated, would jointly raise premiums by 0.3 percent. Because plans could require enrollees to exhaust all internal appeals before taking a grievance to the external review board, the number and type of claims that the external review board would consider would depend on the stringency of the internal appeals process. Conversely, having an external appeals process with binding authority over plans would affect both the number of internal appeals and the likelihood that the plan would decide in favor of the beneficiary.

Section 131—Establishment of Grievance Process. The bill would require group health plans and health insurance issuers to establish a system to provide for the presentation and resolution of grievances brought by enrollees or their representatives, including their health care providers, regarding any aspect of the plan's services. Plans would have to provide written notification to enrollees of whom to contact in the event of a grievance or appeal, establish systems to record and document all grievances and appeals and their status, develop a process for timely processing and resolution of grievances and for follow-up actions, and ensure that the continuous quality improvement program would be informed of any grievances relating to the quality of care.

Section 132—Internal Appeals of Adverse Determinations. This section would establish an enrollee's right to appeal a wide range of decisions by their health plan, including denial, reduction, or failure to provide or pay for a benefit; failure to provide emergency coverage, choice of providers, qualified providers, access to specialty care, continuation of care if an enrollee's provider was terminated, access to necessary prescription drugs, or coverage of clinical trials; adverse utilization review decisions; and arbitrary interference with the physician's decision on the manner or setting of care, when the care was medically necessary or appropriate.

The bill would require individuals conducting internal reviews to include clinical peers who had not previously been involved in the decision under appeal. Clinical peers would be physicians or other health professionals with qualifications in the specialty that typically managed the condition or treatment involved in the appeal, but only a physician would be considered the clinical peer of another physician.

Group health plans and health insurance issuers would face limits on the time for resolving an appeal, which would vary according to the urgency of the situation. They would have to resolve expedited appeals within 72 hours of receiving them and all other appeals within 30 working days.

CBO's estimate assumes that although most health plans have functioning internal review systems, they would experience an increase in the rate of internal appeals per enrollee, as a result of greater consumer knowledge of the appeals process and the availability of external review. A recent study by the General Accounting Office suggests that data on internal appeals rates are highly unreliable and vary widely among HMOs.[5] The range of self-reported appeal rates was 0.07 to 69.4 per 1,000 enrollees, with a median of 3.5. Those rates, however, included appeals for the denial of emergency services, which might occur less frequently under the bill because of the "prudent layperson" provisions. CBO's estimate, therefore, assumes a current average appeal rate, excluding appeals relating to emergency services, of 2.5 per thousand enrollees.

Health plans and health insurance issuers with internal appeals processes in place would still incur cost

increases under the bill because of higher rates of appeal and higher costs per appeal. But appeal rates and costs will rise somewhat even without the legislation. Increases will occur under current law if proposed regulations affecting internal claims procedures for ERISA health plans proposed by Department of Labor (DoL) are adopted.[6] The regulations will require ERISA plans to provide enrollees whose claims are denied with information on their appeal rights and will require plans to meet tighter timeframes both for the initial review of claims and for subsequent appeals.

Nonetheless, CBO assumes that the enactment of this bill would raise internal appeals rates among ERISA plans, as well as among the non-ERISA plans that would be required to comply. Because of the provisions for external review of denied appeals and the penalties for health plans that did not comply with the legislation, the bill would provide much stronger incentives for internal appeals than the DoL regulations alone.

Costs per appeal would also rise for ERISA and non-ERISA plans as a result of the legislation. Factors contributing to higher costs include:

- The requirement for review by a clinical peer, which will result in higher professional costs for internal appeals and
- Higher rates of appeals being overturned in favor of enrollees, reflecting plans' desire to avoid external review.

Plans would attempt to reduce the cost of appeals by applying less stringent utilization review standards to appealable decisions, provided that such responses would lower their overall expected costs.

Cost increases would be larger for the small minority of health plans and issuers that do not currently have systems for internal review of grievances in place. They would experience a significant increase in administrative costs as well as the costs associated with overturned decisions resulting from appeals.

Section 133--External Appeals of Adverse Determinations. This section would require all health plans and health insurance issuers to establish a process whereby enrollees could appeal plans' decisions to an external review organization, which would provide a *de novo* determination of the merits of the clai... Decisions in any of the internal appeal categories would be eligible for further appeal if the costs at issue exceeded a significant threshold, or if the patient's life or health would be jeopardized. The plan or issuer could require the appellant to exhaust the internal appeals process first before taking a claim to external review. But enrollees could take a claim directly to external review if the plan failed to comply with the deadlines for internal appeals in the law. The decision of the external review organization would be binding on the plan or issuer but would not affect the enrollee's right to seek judicial remedies in the courts. Decisions would have to be made within 60 days of filing notice of appeal or 72 hours in the case of expedited appeals.

Plans and issuers would have to contract with qualified external appeals entities. States could designate such entities for health insurance issuers and the appropriate Secretary for group health plans. External review organizations would have to meet certification and recertification requirements imposed by the states or the Secretary of Labor. But if a state did not establish an adequate certification and recertification process, the Secretary of Health and Human Services would fulfil that function.

Although about half of the states already require external appeals processes, few claims are appealed. Various factors appear to have contributed to that outcome, including:

- Lack of awareness by enrollees of their external appeal rights because programs are new or not

widely promoted;

- Coverage of certain functions only, such as experimental procedures;
- Uncertainty about whether the state's requirements are preempted by ERISA; and
- Sentinel effects of having an external review program, which causes plans to modify their internal review procedures.

Florida is one of the few states that appears to have a program that is functioning at much more than a minimal level. And even Florida's rate of external appeals, about 1 per 10,000 enrollees, is only about one-tenth of the external appeals rate in the Medicare program.[(7)] The Medicare rate, however, is higher than would be expected under the bill because every form of denial in Medicare is subject to appeal, and all appeals that plans deny are automatically referred to external review.

For the purposes of this estimate, CBO assumed that the legislation would significantly increase external appeals rates, even in those states that nominally have external review requirements. Moreover, those rates would rise over time as enrollees became more aware of their rights to such reviews. Nonetheless, external review rates would remain relatively low when compared to internal appeals rates (which plans would be more likely to resolve in favor of the enrollee if an external review option was available). Specifically, CBO estimated that external appeals rates would rise to about 4 per 10,000 enrollees after 5 years.

Protecting the Doctor-Patient Relationship

Subtitle E contains four provisions governing plans' contracts with providers.

Section 141–Prohibition of Interference. This section, an anti-gag-rule provision, would void any provision of a contract that limited a provider's freedom to discuss or communicate with a patient about aspects of his or her care. Several studies have shown that few plans impose such restrictions today. For those that do, their costs associated with this provision would be minimal.

Section 142–Prohibition of Improper Incentive Arrangements. This section would prohibit provisions in contracts between health plans and providers that transferred liability for decisions of the plan to the provider or rewarded the provider for decisions regarding specific patients. Although health plans might seek to reduce their own potential liability for medical negligence under the bill by transferring that liability to providers, their costs would not be affected because they would have to pay more to providers to cover the transferred costs of liability. The prohibition of physician incentive plans that financially reward or penalize physicians for decisions involving specific patients would follow guidelines promulgated for Medicare HMOs. Those guidelines require physicians who take substantial financial risks to have stop-loss insurance covering the risk of high-cost patients. The section would have a small impact on premiums overall.

Section 143–Participation of Health Care Professionals and Section 144--Protection for Patient Advocacy. These sections would establish protections for providers that generally do not exist in health plans today. Section 143 would specify due process standards for selective contracting between plans and health care professionals. Section 144 would protect providers (and enrollees) from retaliation for participating in the appeals and grievance process or for disclosing information on the quality of care to a plan or regulatory agency. Under title III, physicians and other professionals could appeal adverse contractual decisions by ERISA health plans to the Secretary of Labor on the basis of this provision. Title III also would prohibit retaliation against professionals by institutional health care providers.

Although these protections would be largely procedural (for example, requiring written rules on participation but not dictating the content of those rules), they would require plans to establish regulatory compliance operations for their contractual interactions with providers. Plans would not only need to establish compliance with sections 113, 143, and 144, but they would also have to defend against the threat of appeal through careful documentation of all contract actions. Thus, although these sections fall well short of constituting any-willing-provider provisions, they would entail some administrative costs.

The provisions would fall most heavily on managed care plans with broader networks, such as preferred provider organizations and independent practice associations, which do not typically have exclusive arrangements with physicians and hospitals. CBO estimates that the incremental costs of these provisions would be 0.2 percent of premiums.

Promoting Good Medical Practice

Subtitle F contains a specific benefit mandate and a more general provision prohibiting arbitrary interference with medical practices. The benefit mandate relates to treatment of breast cancer.

Section 151—Promoting Good Medical Practice. This section would prohibit plans from arbitrarily interfering with or arbitrarily altering the manner or setting of care when that care is medically necessary or appropriate. Manner or setting would be defined as the location of treatment and the duration of service but would exclude decisions on the plan's coverage of particular services or treatments. The section defines medically necessary or appropriate care as care that is "consistent with generally accepted principles of professional medical practice." Grievances regarding the plan's conformance with this section could be appealed under subtitle D. Members of ERISA plans could also sue in federal court to seek remedies under this provision.

This section could affect plans in two ways. First, it would increase the expected costs of utilization review and reduce the potential savings from such activities. Second, it could restrict plans' ability to use more indirect methods of influencing utilization, such as financial incentives for education of providers.

The section would establish the right to appeal plans' utilization review decisions about the appropriateness of inpatient, outpatient or home care for procedures or treatments, monitoring of high risk patients, and administration of medications, as well as all decisions about lengths of inpatient stays. Any decisions regarding those categories of care would be subject to the provision's definition of medical necessity.

Because the provision would put the burden on the plan to prove that a given practice was not "consistent with generally accepted principles of professional medical practice" any appeal would require the plan to develop substantial evidence that the physician's decision was unreasonable. This provision would increase the volume of internal and external appeals above and beyond the volume expected from other provisions. Not only would the provision provide additional incentives to appeal decisions by plans, but it would probably also lead to a higher rate of reversal on appeal. Although the external appeals bodies might eventually settle on uniform and easily interpreted standards of medical necessity, the variability of medical practice styles across the country would ensure continuing challenges to decisions by plans over the 10-year estimating period.

One way for plans to avoid appeals under this provision would be to reduce the frequency with which they challenged physicians' decisions. CBO took account of the likelihood that plans would adopt defensive utilization review practices when the costs of such changes to the plan were lower than the expected costs of the internal and external review actions required to defend the UR policies. The burden of this provision would fall more heavily on those health plans with broader networks which rely on utilization review to influence patterns of care. Traditional indemnity plans with utilization review components, preferred

provider organizations, and non-capitated independent practice association-model HMOs would face more appeals than would group- or staff-model health maintenance organizations. CBO estimates that the higher volume of internal and external appeals and the higher probability of decisions unfavorable to plans would raise premiums by 0.8 percent overall.

Section 152--Standards for Breast Cancer Treatment. Section 152 would prohibit health plans from limiting hospital lengths of stay for mastectomies to less than 48 hours and for lymph node dissections for breast cancer to less than 24 hours. The provider would not have to obtain prior authorization for any length of stay for those conditions. CBO estimated that these two provisions would add less than 0.05 percent to health plan premiums.

Changes to the Employee Retirement Income Security Act

Title III of the bill would apply the patient protection standards of title I to group health plans and group health insurance coverage under ERISA. The estimated costs of these standards were discussed above. In addition, title III would impose additional regulatory costs on the Department of Labor and would alter the legal liability of health insurance plans under ERISA.

Enforcement by the Department of Labor. Section 301 would permit any health care professional who has been discriminated against or retaliated against to file a complaint with the Secretary of Labor. The Secretary would be required to investigate these complaints to determine if a violation had occurred. If a violation occurred, the Secretary would issue an order to ensure that the health professional did not suffer any loss of position, pay or benefits from the plan. Costs associated with this enforcement include the expenses associated with tracking and investigating complaints by providers. CBO estimates that these costs would total $190 million over the 2000-2004 period, assuming appropriation of the necessary amounts.

Legal Liability for ERISA Plans. As a result of ERISA, enrollees in employer-sponsored health plans are generally unable to seek legal remedies under state law for damages resulting from the actions or decisions of their health plans. They may seek redress only in federal court under the provisions of ERISA, which limits any damages to the cost of the plan benefits under dispute and, in some cases, attorneys' fees and court costs. In recent years, ERISA case law has evolved, with some federal courts ruling that enrollees can sue their plans in state courts for vicarious liability for the medical negligence of the plan's providers. But disputes over benefits and administration have largely been preempted by ERISA.

The bill would amend ERISA to allow enrollees in employer-sponsored plans (or their estates), under certain circumstances, to sue their health plans under state law for damages resulting from personal injury or wrongful death. Specifically, enrollees could sue a person if personal injury or wrongful death resulted from that person's provision of insurance, administrative, or medical services to or for a group health plan, or arose out of their arrangement for the provision of insurance, administrative, or medical services by others. The bill would protect employers and other plan sponsors from suits as long as the action that led to the suit did not reflect the exercise of discretionary authority by the employer or sponsor. The cost of this provision depends on assumptions for which the supporting data are extremely limited or nonexistent. CBO therefore consulted with many experts nationwide on the likely outcomes of this provision and received a broad range of opinions.

Some experts believe that ending the ERISA preemption for health plan liability would increase costs only slightly. They maintain that the bill would do little more than speed up trends that are already underway in the courts of holding ERISA plans accountable for the medical negligence of their providers and treating adverse outcomes resulting from decisions on medical necessity by health plans as medical negligence. Health plans could limit their liability for decisions on medical necessity by including more explicit

coverage statements in their contracts and by using binding arbitration or other alternative dispute resolution techniques. Moreover, the external review requirements in the bill would limit the number of cases that would be litigated, and the caps on tort liability that exist in more than half of the states would limit the size of awards. These experts also argue that the experience of state and local government health plans and among plans in the individual insurance market, all of which are exempt from ERISA and potentially subject to litigation, suggests that litigation over issues relating to denial of coverage is likely to be small.

Others believe that ending the ERISA preemption would fundamentally change the environment in which private employer-sponsored plans operate and increase their costs considerably, not only as a result of litigation but also because of the defensive utilization review strategies that plans would adopt. They predict that health plans would be sued along with providers for medical malpractice much more frequently when patients were injured, because of the plans' "deep pockets" and because lawyers would not have to deal with potential issues of ERISA preemption and would be attracted by the large damages that juries might award. A big increase in suits over decisions on medical necessity and denial of coverage would probably occur, they contend, with providers as well as beneficiaries seeking damages. Health plans' attempts to limit coverage contractually could be thwarted by arguments that such contractual restrictions were another form of practicing medicine and, hence, subject to suit. Whether state tort liability caps would apply to health plans is uncertain and would probably vary among the states. In addition, the language in the bill protecting employers and sponsors who were not exercising discretionary authority would not protect the fiduciaries of ERISA plans who, by definition under the law, exercise such authority. Proponents of these views also argue that the experience of non-ERISA plans does not throw much light on what would probably happen in the ERISA market because of differences in the covered populations (including the degree of unionization), appeals processes, plan generosity, and choice of plan, as well as states' ability to limit their legal liability. They envision the emergence of an aggressive plaintiffs' bar that would declare open season on health plans.

The bill includes several provisions designed to address some of those concerns:

- Only plan participants and beneficiaries (or their estates) would have standing to file suit;
- The term "personal injury" is defined to mean physical injury, including an injury arising out of the treatment, or failure to treat, a mental illness or disease;
- The limitation on suits against employers and plan sponsors also includes their employees when acting within the scope of their employment; and
- A construction clause establishes that nothing in section 302 should be construed as permitting a cause of action under state law for the failure to provide an item or service that the group health plan did not cover.

Regardless of the extent to which they are subject to suit under current law, all health plans are already, directly or indirectly, incurring significant liability costs. Most of those costs relate to medical negligence, as litigation over coverage questions has been relatively rare (in part, because of the ERISA preemption). Tightly managed plans are at risk for being held vicariously liable for the medical negligence of their providers. To offset that risk, they may purchase liability insurance, establish mandatory arbitration procedures, or increase their oversight and monitoring of providers. Loosely managed and indemnity plans pay liability costs indirectly through the rates that they pay to providers, which include those providers' liability insurance costs. Those types of plans also pay for additional services that result from physicians' defensive practices. CBO estimates that health plans' liability costs average about 2 percent of their premiums (not counting defensive medicine by providers).

Several factors could cause plans' expected liability costs to rise.

- More medical negligence suits would be filed against ERISA plans, and the amount of damages awarded would rise, as plaintiffs would have another party to sue in addition to the provider. Although some of those suits are occurring now, dealing with the issue of ERISA preemption is a disincentive for many medical malpractice lawyers and reduces the number of suits that are filed.

- Expected liability costs associated with decisions on medical necessity and coverage would increase significantly. At present, there are few coverage suits against ERISA plans as a result of the preemption, and the associated liability costs are low. Ending the ERISA preemption would mean not only that more plans would be successfully sued but, more importantly from a cost perspective, every judicial decision awarding damages to a plaintiff for a plan's coverage decision would increase the risk of suit for all other plans with similar coverage policies. Several of the experts whom CBO consulted mentioned the *Fox v. Health Net* suit as an example of that phenomenon.[(8)] The jury in *Fox* awarded the plaintiff, a breast cancer patient, $89 million for denial of coverage of autologous bone marrow transplantation (ABMT). Although the case was subsequently settled for a much lower amount, expected liability costs rose for all health plans with similar coverage standards for ABMT. Consequently, many plans apparently took action to reduce their risks from such suits, changing their utilization review criteria for ABMT so that the treatment became much more widely utilized. (Plans could have handled the increased risk in a variety of ways, of which loosening their utilization review criteria was just one. Alternatively, they might have increased their liability insurance or changed the coverage standards written into their contracts with enrollees.) Two recent suits (*Johnson v. Humana and Goodrich v. Aetna U.S. Healthcare of California, Inc.*) provide further indications of the potential for juries in state courts to award large punitive damages to enrollees who argue that they have been injured by their plans. Such awards serve as sentinel events that can have far-reaching effects on the behavior of all health plans, not just those that are sued.

- The bill is likely to result in a variety of unforeseen lawsuits against health plans--including suits instigated by providers and suits against plan fiduciaries. Section 302 would raise new issues regarding the extent of the ERISA preemption that could take the courts a long time to address.

- In addition to the increase in direct liability costs that plans would face, plans would also have to consider the indirect costs associated with the adverse publicity that litigation engenders. Adverse publicity could result in loss of market share, adding to plans' expected liability costs.

Taking all of those factors into account, CBO estimates that ending the ERISA preemption of legal liability for private employer-sponsored plans would increase liability costs by 70 to 90 percent, in the case of PPOs, POS plans, and HMOs, and by a lesser percentage in the case of indemnity plans. Those increases represent, on average, about 1.4 percent of the premiums of all employer-sponsored plans. Those estimates take into account all of the actions that plans take to lessen their liability costs, including the purchase of liability insurance and changes in utilization review criteria and coverage standards intended to reduce the probability of lawsuits.

Under CBO's assumptions, more than half of the increase would arise from potential suits associated with decisions on medical necessity and coverage (and the associated behavioral responses by plans), as well as lawsuits involving providers and plan fiduciaries. Most of the remainder would result from more medical negligence suits against plans, reflecting the financial resources of health plans and the effects of the new legal environment. The estimate also assumes that a further loosening of review criteria and standards of medical necessity (with a corresponding increase in costs) would result from the desire of plans to avoid the adverse publicity of litigation.

Questions have been raised about the impact of the health plan liability provisions on small self-insured firms. Advocates for small businesses argue that liability insurance is not currently available for such firms, and they would be unlikely to remain self-insured without liability coverage if the ERISA preemption was lifted. Purchasing a fully-insured plan from an insurer or an HMO, which the firms might feel compelled to do, would increase their insurance costs because they would have to pay for benefits mandated by the state as well as state premium taxes. In addition, they could face a one-time cash flow problem because they would have to start making premium payments to an insurer while they were still paying off the tail of claims from their own plan.

Although temporary dislocations might occur when these provisions first came into effect, insurance markets would almost certainly respond to the demand for liability coverage for health plans. Third-party administrators that service small self-insured plans, and insurers that offer risk-sharing arrangements to such plans, would have a strong incentive to develop the means for self-insured plans to obtain liability coverage. In order for liability insurers to be willing to provide such coverage at a reasonable premium, however, the plans might have to accept more oversight and standardization of their coverage policies, which could increase their costs. In addition, obtaining liability coverage for punitive (as opposed to compensatory) damages might be a problem in the 15 or so states in which the courts have ruled that punitive damages are not insurable. But punitive damage awards are capped in at least some of those states, which would limit the risk for a firm without coverage for punitive damages.

The transition period until liability coverage was more generally available could be difficult for some self-insured firms, with some of them opting to purchase fully insured products rather than face an uncertain risk of liability. To the extent that response occurred, average premium costs would be higher than they otherwise would be, but the effects would diminish over time as markets for liability insurance developed. Offsetting any subsequent decline in premiums, however, would be rising costs resulting from the growth in liability suits as more consumers (and their lawyers) became aware of their rights to sue health plans.

Two other factors would have offsetting effects on the costs of ending the ERISA preemption for health plan liability. On the one hand, some experts believe that the courts will continue on their current path of limiting the extent of the ERISA preemption, not only for medical negligence but also for decisions on medical necessity and coverage. Insofar as that occurred, then the additional costs resulting from this legislation would be lower, although there is considerable doubt about how long it would take to establish this expanded body of ERISA case law. On the other hand, ending the preemption could have long-term consequences for the development and adoption of costly new technologies. Research suggests that the spread of managed care may have slowed the rate of adoption of new medical technologies, helping to contain the rate of growth of health spending.[(9)] Because the bill would allow enrollees to sue plans for their decisions on medical necessity and coverage, the dissemination of new technologies would speed up, encouraging further technological development and raising costs.

Other Federal Administrative Costs

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the Secretary of HHS to enforce provisions of HIPAA that apply to group or individual health insurance if she determines they not being enforced by a state. The Secretary currently enforces provisions of HIPAA in four states.

The Secretary would also be required to enforce the provisions of this bill, as they apply to group and individual health insurance, if she determines they are not being enforced by a state. CBO assumes that enactment of those provisions would increase to five the number of states subject to Federal enforcement. Over ten years, however, the number of states subject to Federal enforcement would decline to one. The

estimate assumes that the average cost per state of enforcing S.6 would be the same as the average cost of enforcing HIPAA. Assuming appropriation of the necessary amounts, federal discretionary spending would increase by $5 million in 2000, and by $55 million in 2000-2004.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the Table 3. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted. As noted earlier, this bill could reduce some of the savings associated with the spillover effect of managed care. Due to uncertainty about the existence or magnitude of the change, CBO has not included an estimate of Medicare costs.

TABLE 3.
ESTIMATED PAY-AS-YOU-GO EFFECTS OF THE PATIENTS' BILL OF RIGHTS ACT

	By Fiscal Year, in Millions of Dollars									
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Change in Revenues	-270	-680	-1,070	-1,320	-1,530	-1,660	-1,750	-1,850	-1,950	-2,060
Change in Outlays	5	10	20	25	35	40	45	45	50	55

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

The PHSA allows state, local, and tribal governments to elect not to have certain federal requirements apply to their own group health plans. The requirements for state, local, and tribal governments in this bill would also be optional under the provisions of the act. Consequently, the bill does not contain intergovernmental mandates as defined in UMRA. The bill would affect the budgets of state, local, or tribal governments only if they chose to comply with the requirements on group health plans. If they chose to apply the bill's requirements to their own health plans, the budgetary impact on state, local and tribal governments could be significant. Because the bill imposes a number of new requirements on insurance issuers, state and local governments also may face increased costs if they offer fully insured products as part of their employee benefits plans. The bill would provide grants to states to establish a health insurance ombudsman, but in the absence of state activity, the federal government would assume responsibility for the office.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains several private-sector mandates as defined in the Unfunded Mandates Reform Act. CBO

estimates that the direct cost of those requirements to private sector entities would significantly exceed the threshold specified in UMRA ($100 million in 1996, adjusted annually for inflation) in every year following enactment (see Table 4).

TABLE 4.
ESTIMATED DIRECT COST OF THE PRIVATE-SECTOR MANDATES IN THE PATIENTS' BILL OF RIGHTS ACT

	By Fiscal Year, in Millions of Dollars				
	2000	2001	2002	2003	2004
Provisions in Title I[a]	2,900	6,200	8,700	10,700	12,900

SOURCE: Congressional Budget Office.

a. Includes the items listed in Table 2, with the exception of sections 116, 123, and 302.

Most of the provisions of title I would impose requirements on both group and employer-sponsored health plans and on health insurance issuers. The mandatory point-of-service requirement in section 102 would affect only group and employer-sponsored plans, however, and the continuity of care requirement in section 105 would have almost all of its effect on that market as well. The provisions establishing the Health Care Quality Advisory Board (section 116) and the Health Insurance Ombudsman (section 123) would not impose mandates on private sector entities. CBO estimates that the total direct costs of the mandates in title I would be about $3 billion in 2000 and would reach about $13 billion in 2004. The costs in 2004 would represent about 3.4 percent of total private-sector health insurance expenditures, although their distribution among health insurance plans would be uneven.

Section 302 would amend ERISA to allow enrollees in employer-sponsored plans to sue their health plans under state law for damages resulting from personal injury or wrongful death. That provision would not constitute a mandate on private health plans. Rather, it would convey a new right that members of ERISA plans could exercise at their discretion.

COMPARISON WITH PREVIOUS ESTIMATES

On April 23, 1999, CBO provided an estimate of S. 6, as introduced. This estimate reflects two modifications offered by the sponsors.

The first modification deletes subparagraph 132(c)(2)(C) of the introduced bill, which required appeals to be expedited at the request of a physician. This change reduces the estimated increase in premiums for employer-sponsored health insurance by about 0.3 percentage points.

The second modification adds a new section 502(n) of ERISA, which would limit the ability of participants in health plans to bring legal actions to enforce certain provisions of S. 6 under subsections 502(a)(1)(B), 502(a)(2), and 502(a)(3) of ERISA. Under the bill as modified, participants could not initiate class actions or sue to obtain plan-wide injunctive relief under these provisions of ERISA. Legal relief would be limited to the provision of or payment for benefits or services denied to the individual participant. The limitation

would not apply to complaints of discrimination in the delivery of services under section 109 of S. 6. This change reduces the estimated increase in premiums for employer-sponsored health insurance by 1.0 percentage point.

ESTIMATE PREPARED BY:

Federal Cost Estimate: Linda Bilheimer, Tom Bradley, Cyndi Dudzinski, and Judith Wagner
Impact on State, Local and Tribal Governments: Leo Lex
Impact on the Private Sector: Judith Wagner

ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis

---

1. Most of the provisions of the bill were extended to the Federal Employees Health Benefits Program under a Presidential memorandum of February 20, 1998. On April 9, 1999, the President announced that two additional provisions would be included. This estimate includes the costs of the provisions of the bill that cannot be implemented administratively.

2. Health Policy Economics Group, Price Waterhouse, LLP, "The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals from California" (November 1997).

3. Robert E. Mechanic and Allen Dobson, "The Impact of Managed Care on Clinical Research: A Preliminary Investigation," *Health Affairs*, Fall 1996, vol. 15, no. 3, pp. 72-89.

4. U.S. General Accounting Office, *Consumer Health Care Information: Many Quality Commission Disclosure Recommendations are Not Current Practice*, April 1998 (GAO/HEHS-98-137).

5. U.S. General Accounting Office, *HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent*, GAO/HEHS-98-119 (May 1998).

6. Federal Register, Wednesday, September 6, 1998, Department of Labor, Employee Retirement Income Security Act of 1994; Rules and Regulations for Administration and Enforcement; Claims Procedure; Proposed Rule.

7. Allen Dobson and others, "Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals" (report submitted by The Lewin Group, Inc., to the Presidential Commission on Consumer Protection and Quality in the Health Care Industry, November 1997).

8. *Fox v. Health Net*, Riverside Superior Court, March 26, 1994.

9. David M. Cutler and Louise Sheiner, *Managed Care and the Growth of Medical Expenditures*, (NBER Working Paper No. 6140, Cambridge, MA: National Bureau of Economic Research, August 1997).

CBO Home Page | Search Page

would not apply to complaints of discrimination in the delivery of services under section 109 of S. 6. This change reduces the estimated increase in premiums for employer-sponsored health insurance by 1.0 percentage point.

ESTIMATE PREPARED BY:

Federal Cost Estimate: Linda Bilheimer, Tom Bradley, Cyndi Dudzinski, and Judith Wagner
Impact on State, Local and Tribal Governments: Leo Lex
Impact on the Private Sector: Judith Wagner

ESTIMATE APPROVED BY:

Paul N. Van de Water
Assistant Director for Budget Analysis

---

1. Most of the provisions of the bill were extended to the Federal Employees Health Benefits Program under a Presidential memorandum of February 20, 1998. On April 9, 1999, the President announced that two additional provisions would be included. This estimate includes the costs of the provisions of the bill that cannot be implemented administratively.

2. Health Policy Economics Group, Price Waterhouse, LLP, "The Impact of Managed Care Legislation: An Analysis of Five Legislative Proposals from California" (November 1997).

3. Robert E. Mechanic and Allen Dobson, "The Impact of Managed Care on Clinical Research: A Preliminary Investigation," *Health Affairs*, Fall 1996, vol. 15, no. 3, pp. 72-89.

4. U.S. General Accounting Office, *Consumer Health Care Information: Many Quality Commission Disclosure Recommendations are Not Current Practice*, April 1998 (GAO/HEHS-98-137).

5. U.S. General Accounting Office, *HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent*, GAO/HEHS-98-119 (May 1998).

6. Federal Register, Wednesday, September 6, 1998, Department of Labor, Employee Retirement Income Security Act of 1994; Rules and Regulations for Administration and Enforcement; Claims Procedure; Proposed Rule.

7. Allen Dobson and others, "Consumer Bill of Rights and Responsibilities Costs and Benefits: Information Disclosure and External Appeals" (report submitted by The Lewin Group, Inc., to the Presidential Commission on Consumer Protection and Quality in the Health Care Industry, November 1997).

8. *Fox v. Health Net*, Riverside Superior Court, March 26, 1994.

9. David M. Cutler and Louise Sheiner, *Managed Care and the Growth of Medical Expenditures*, (NBER Working Paper No. 6140, Cambridge, MA: National Bureau of Economic Research, August 1997).

CBO Home Page Search Page

Look Up Term

Please select a format in which to retrieve a document.

Online HTML | Adobe PDF | PostScript | Corel WordPerfect

Click here to read a description of our document formats.

CBO TESTIMONY

Statement of
Dan L. Crippen
Director
Congressional Budget Office

on
Health Care Costs and Insurance Coverage

before the
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives

June 11, 1999

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the relationship between health care costs and insurance coverage. Despite several factors that might boost health insurance coverage--such as the booming economy, expansions in Medicaid eligibility, state insurance reforms, federal legislation to improve the portability of health insurance, and several years of slow growth in health insurance premiums--the percentage of Americans who lack health insurance has grown. The number of people without insurance is likely to continue to increase, although that growth will be moderated by federal and state initiatives to expand coverage (such as the State Children's Health Insurance Program). Health insurance premiums will grow more rapidly than in the recent past, and more low-income families will move off the welfare rolls and Medicaid into entry-level jobs that do not offer coverage. Policies that further increase health care costs and premiums could result in larger reductions in insurance coverage than might otherwise occur.

My testimony today will outline what we know about the characteristics of the uninsured population and describe recent trends in health care costs and insurance coverage. Most of my remarks will focus on how policies that mandate benefits or impose other standards on health plans may contribute to higher premiums and lower coverage rates.

CHARACTERISTICS OF THE UNINSURED POPULATION

According to the Current Population Survey (CPS), about 43 million people under age 65 lacked insurance coverage in 1997.[1] That estimate represented 18.3 percent of the nonelderly population and compares with 14.8 percent who lacked coverage a decade earlier. Most uninsured people were in working families, and one-quarter of them were children. More than half of them were in families with income below 200 percent of the poverty level.

Low-wage workers and those in small firms are much more likely to lack coverage than other workers. Most low-wage workers with access to employer-sponsored coverage--either through their own employer or that of a family member--enroll in employer-sponsored plans. But they are much less likely than other workers to have access to employer-sponsored coverage from any source. In 1996, for example, 55 percent of workers earning up to $7.00 an hour had access to employer-sponsored coverage from any source

compared with 96 percent of workers earning more than $15.00 an hour. Similarly, 63 percent of workers in firms with fewer than 10 employees had access to such coverage compared with 93 percent of workers in firms with more than 100 employees.(2)

The percentage of the population that is uninsured varies widely among the states, ranging from less than 15 percent in most midwestern and New England states to more than 20 percent in California and some of the southwestern states. That variation reflects differences in population characteristics, such as per capita income and the proportion of recent immigrants, and in labor force characteristics, such as the distribution of workers among different industries and the extent of unionization. States also differ in their policies regarding Medicaid eligibility, rules relating to the accessibility and affordability of coverage in the small-group market, and the extent to which they impose benefit mandates and other requirements on health insurance.

TRENDS IN HEALTH CARE COSTS AND INSURANCE COVERAGE

Competition among health plans, and the associated shift from indemnity to managed care plans, contributed to a dramatic slowdown in the growth of health insurance premiums in the 1990s. On average, the annual rate of increase in premiums fell from double-digit levels in the late 1980s and early 1990s to 2 percent or less in 1995 through 1997. Over the past year, however, premiums have begun to grow more rapidly again as health plans that had held down premiums to capture a larger market share seek to improve their profit margins. Some analysts and health plans are predicting increases in the range of 6 percent to 10 percent in both 1999 and 2000. Others are predicting even larger hikes.

Rates of insurance coverage for both adults and children declined over the 1987-1997 period, and that decline appears to be continuing. Data from the CPS indicate that coverage of nonelderly adults fell fairly steadily until 1992 and then remained relatively stable before declining again in 1997. The percentage of nonelderly adults who were uninsured rose from 15.6 percent to 19.7 percent during the period. Coverage of children increased slightly from 1987 to 1992 and then started to fall. In 1997, 15 percent of children were uninsured.

Analysis based on the CPS suggests that the reductions in coverage rates that occurred between 1987 and 1992--a period in which premiums were growing rapidly--were attributable primarily to lower rates of employer-sponsored insurance.(3) One cannot, however, infer causality solely on the basis of that apparent association. Subsequent declines appeared to be attributable mainly to falling rates of Medicaid coverage, with the proportion of the population with employer-sponsored insurance remaining relatively steady through 1997.

Another recent study, which was based on data from other surveys taken in 1987 and 1996, found that the proportion of workers with employment-based coverage from any source fell from 76.2 percent to 73.2 percent over that period.(4) The study suggested that the decline generally resulted from lower rates of participation in employer-sponsored plans rather than reductions in the rate at which employers offer coverage. For low-wage and young (under age 25) workers, however, the proportion with access to employer-sponsored coverage (through their own job or that of another worker in the family) fell, as did their participation rates.

IMPACT OF INCREASING PREMIUMS ON COVERAGE

Health care costs are rising for many reasons including changes in medical practice, the development of costly new technologies, and greater use of prescription drugs and other services. A 1998 article in the *Wall Street Journal*, for example, described some of the new high-cost technologies that had recently come onto the market.(5) They included new brain surgery techniques for treating Parkinson's disease, three different $10,000-a-year drugs for treating multiple sclerosis, and improved inhalers for asthma patients that cost three times as much as other inhalers. Technological breakthroughs are also resulting in a wide range of powerful new drugs including antidepressants, medications for acquired immunodeficiency syndrome (AIDS), and drugs for reducing cholesterol levels. Demand for such drugs is being driven in part by direct-to-consumer advertising, and many health plans are reporting that their drug costs are soaring. Those rising costs are redistributed in the health care system in various ways including changes in covered health insurance benefits, higher premiums for health insurance, and reductions in coverage.

Government regulation at both the state and federal levels can also increase the costs of health insurance and lead to higher premiums. Examples of such regulations include:

- Mandates to cover specific benefits such as chiropractic services or minimum hospital stays for births;
- Regulations to change the way in which health plans operate--for example, requiring appeals procedures when benefits are denied or reducing insurers' ability to reject applicants with preexisting conditions; and
- Taxes on health insurance premiums.

States also regulate the premiums that insurers charge for health policies, often by requiring premiums charged to small firms to fall within specified limits. Such regulation is frequently thought to keep premiums affordable for employees in those firms. Higher-risk groups have lower insurance costs because of the upper premium limit. But the lower premium limit is generally higher than insurers would charge to the good risks--people who are healthier and less likely to use health services. Consequently, the good risks tend to drop their coverage, which raises the average cost of insurance for those who remain in the small-group market.

The Congressional Budget Office (CBO) assesses the likely private-sector costs of proposed federal mandates on health insurers and health plans as part of its duties under the Unfunded Mandates Reform Act of 1995 (UMRA). The act requires CBO to estimate the aggregate amount that private-sector entities would have to spend to comply with the mandates, assuming that such entities take all reasonable steps to mitigate those costs. CBO's analysis is limited to the costs of the proposed legislation and does not consider its benefits. In recent years, CBO has analyzed proposals to require parity in the provision of mental health services, to ensure access and portability of insurance coverage, and, more recently, to expand patients' rights.

CBO's analysis of a proposed health insurance mandate takes into account how employers who offer health coverage would react to the additional costs imposed by the mandate. Employers might respond to such costs by reducing the generosity of insurance coverage, perhaps by raising cost-sharing requirements imposed on beneficiaries or by eliminating some benefits. Some employers might drop health coverage altogether. They might also reduce the generosity of other employee benefits or the size of wage increases. Such actions limit the rise in labor costs that would otherwise occur because of an insurance mandate.

Employees and others buying insurance in the individual market would also respond to rising health insurance costs. Some would drop their coverage as premiums increased, while others would select less

generous coverage if that option was available. Even beneficiaries who retained their health coverage without change after enactment of an insurance mandate would be affected, since their costs would increase.

In general, higher premiums are likely to result in some loss of coverage, although the magnitude of the reduction is difficult to predict. One should be cautious, however, about applying a single rule of thumb to assess the effects on coverage of changes in premiums that arise from different sources. Any mandate on health insurance that raises premiums, for example, could cause some decline in coverage--just as an increase in the price of any product could cause demand for that product to fall. But the specific nature of any insurance mandate will affect its impact on coverage. Consequently, potential declines in coverage can be estimated only by analyzing specific legislative proposals individually.

In particular, the loss of coverage that is likely to result from imposing an insurance mandate depends on a number of factors including the following (to simplify the discussion, consider a mandate to add a new benefit):

- A mandated benefit that is highly valued by consumers would cause fewer people to lose insurance coverage than a benefit of lower value having the same cost.
- A mandated benefit that is already offered by many health plans on a voluntary basis would cause fewer people to lose coverage than a benefit that is not commonly offered.
- Some states may already require the mandated benefit, which would lower the impact of the mandate for the nation as a whole. (Employer plans that are fully insured must comply with states' benefit mandates, but those that are self-insured are exempt from those mandates under the Employee Retirement and Income Security Act of 1974, or ERISA.
- A mandate that primarily affects insurance offered by large firms would be expected to lead to a smaller decline in coverage than one that primarily affects small firms. Small firms and their workers are more sensitive to premium increases and are more likely to drop coverage because of a mandate.

CONCLUSION

The number of people without health insurance continues to grow despite the booming economy, expansions in Medicaid eligibility, and other efforts to increase insurance coverage. Rising health care costs have made insurance less affordable for many Americans. Proposals that would impose new mandates on health plans and insurers are meant to improve the value of insurance to consumers, but they could also raise insurance costs and exacerbate the problem of growing numbers of the uninsured. Other proposals are intended to increase health insurance coverage by creating a less regulated environment in the small-group market through such vehicles as association health plans and health marts. Although those proposals could encourage the entry of some lower-cost health plans into the health insurance market, they might also decrease coverage among high-risk groups. Balancing the advantages and disadvantages of competing policies is a significant challenge facing the Congress in the months ahead.

---

1. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," *EBRI Issue Brief*, no. 204 (Washington, D.C.: Employee Benefits Research Institute, December 1998).

2. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987

and 1996," *Health Affairs*, vol. 16, no. 6 (November/ December 1997), pp. 142-148.

3. Fronstin, "Sources of Health Insurance."

4. Cooper and Schone, "More Offers, Fewer Takers." This study uses data from the National Medical Expenditure Survey, 1987, and the Medical Expenditure Panel Survey, 1996.

5. Ron Winslow, " Health Care Inflation Revives in Minneapolis Despite Cost-Cutting," *Wall Street Journal*, May 19, 1998.

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

INTERIM:
716 WEST 4TH AVENUE, SUITE 640
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

SESSION:
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

LETTERS OF SUPPORT
March 20, 2000

Attached is a list of letters of support received by Rep. Norman Rokeberg concerning HB 211.

LastName	FirstName	Organization
		Alaska Physicians and Surgeons
		Alaska State Medical Association
Alexander, MD	David G.	David G. Alexander, MD
Anschuetz, MD, FACC	Richard A.	Alaska Heart Institute
Arita, MD	Adam A.	Adam A. Artia, MD
Armstrong, MD, FACR	Michael B.	Michael B. Armstrong, MD
Baker, MD	Beth	Internal Medicine Associates
Baldauf, MD, FACC	James A.	Alaska Heart Institute
Barnett, MD	Mark R.	
Beacham, MD	Sherman	Sherman Beacham, MD
Bell, MD	Owen R.	Owen R. Bell, MD, Wendy Thon, ANP, RN-C, Martha Linden, CNM, MSN, PC
Bergeson, M.D.	Marvin E.	Tanana Valley Clinic
Bruce	Doug	Provide Alaska Medical Center
Buchanan, MD	Richard	Internal Medicine Associates
(cannot read signature)	Robert	Opthalmic Associates
Cates, MD	J C	J C Cates, MD
Cates, MD	Vern	Vern A Cates, MD
Chen, MD	Barbara M.	Barbara M. Chen
Child, DO	Gary	Medical Park Family Care, Inc.
Coalwell, MD	Timothy	Medical Park Family Care, Inc.
DeKeyser, MD	John	John B. Dekeyser, MD, PC
DeMers, DO, MPH	Mary P.	Mary P. DeMers, DO, MPH
Endres, MD	Donald R.	Geneva Woods Ear, Nose &
Farah, MD	Richard F.	
Farleigh, M.D.	Richard M.	Richard M. Farleigh, MD, PC
Ferris, MD	Glenn A.	Alaska Spine Institute

LastName	FirstName	Organization
Fortson, MD	Jayne	Jayne Fortson, MD
Gerboth, MD	Gregory	Internal Medicine Associates
Gordon, M.D.	Thomas	Alaska Neurological Consultants, LLC
Gordon, M.D.	Thomas	Alaska Neurological Consultants, LLC
Gower, MD	Roland E.	Roland E. Gower, MD
Hadley, MD	Shawn	Alaska Rehabilitation Medicine, Inc.
Hayams, D.O., FACOS	Stephen	Stephan P. Hayms, D.O., LLC
Hummer, MD	Milton T.	Milton T. Hummer, MD
Janis, MD	Burton	Burton Janis, MD
Jayich, Ph.D., MD	Steven	Pathology Associates
Jones, MD	F. Leland	Medical Park Family Care, Inc.
Koval, MD	Janice	Internal Medicine Associates
Krauss, MD	Seth L.	Alaska Heart Institute, LLC
Ladyman, MD	George H.	Health South
LastName	FirstName	Organization
Lawrason, MD	Peter	Fairbanks Clinic
LePique, MD, FACOG	Marcelyn	Marcelyn LePique, M.D.
Lipke, MD,	Robert W.	Robert W. Lipke, MD, APC
Makin, MD	Harbir	Harbir S. Makin, MD
Manuel, MD	Michael D.	Michael F. Manuel, MD
Mason, DO	Bret L.	Orthopaedic Trauma Care
Mayer, MD, FACC, FACP	William P.	American College of Cardiology
McCormic, MD	John J.	Health South
McCray, MD	William	Internal Medicine Associates
McGuire, MD	David A.	David A. McGuire, MD
Mues, MD	John C.	John C. Mues, MD, FACP

LastName	FirstName	Organization
Neubauer, MD, FACP	Richard	Richard L. Neubauer, MD, FACP
Nolan. DO	Patrick M.	Patrick M. Nolan, DO, Inc.
Norman, MD	Michael C.	Michael C. Norman, MD
Nyboer, MD		Dr. Nyboer and Associates
Peach, MD	David	Internal Medicine Associates
Peters, MD	Richard	Richard A. Peters, MD
Richey, MD	Mark E.	Mark E. Richey, MD, PC
Roberts, PA-C	John R.	Orthopaedic Trauma Care
Sahagun, MD	Geronimo	Internal Medicine Associates
Schultes, MD	Glenn	Medical Park Family Care, Inc.
Schultz, DO	John	John Schultz, DO
Senter, MD	Thomas P.	Thomas P. Senter, MD
Smith, MD	Jack Arlyn	Jack Arlyn Smith, MD
Steiner, MD	Griff C.	Griffith C. Steiner, MD
Tamai, MD	Jim	Tanana Valley Clinic
Taylor, MD	R. Randy	Medical Park Family Care, Inc.
Weale, PT	Mary	Alaska Physicial Therapy Association, Inc.
White. MD	R. Matison	Medical Park Family Care, Inc.
Wilder, MD	Norman J.	Norman J. Wilder, MD
Williams, MD	J. David	Geneva Woods Ear, Nose & Throat Associates, Inc.
Worrell, MD	Paul	Paul M. Worrell, MD

Ad Info

Copyright © 2000 The Seattle Times Company

Nation & World : Sunday, March 12, 2000

So far, Texans happy with patient-rights law

by Jim Brunner
Seattle Times Olympia bureau

FORT WORTH, Texas - This week, Gov. Gary Locke is expected to sign a Patient Bill of Rights that will make Washington the fourth state to give its citizens the right to sue health plans for denying medical care.

In passing the legislation, Washington lawmakers from both parties largely ignored the warnings of the health-insurance and **managed-care** lobby, which predicted the law would encourage a flood of lawsuits, cause a big leap in health-**care** costs and price thousands out of health-insurance coverage.

Here in Texas, which in 1997 became the first state to give people the right to sue their health plans, the criticisms sound familiar. The insurance lobby fought tooth and nail against that law, using arguments identical to those now being leveled against the Patient Bill of Rights in Olympia.

But in the Lone Star State, those doomsday predictions haven't come to pass.

"They were saying it was going to be awful, that the apocalypse was going to visit us all," said George Parker Young, a Fort Worth attorney who took on the **managed-care** industry in several lawsuits before the new law. "It hasn't happened."

Only a few lawsuits - estimates are between five and 10 - have been filed in three years under the Texas reforms. The insurance industry acknowledges that the law has so far not driven up health-**care** costs.

And doctors, patients and lawyers in Texas say the statute,

while not perfect, has given them more leverage to demand treatment from their health plans.

Some early doubters have come around, most notably Texas Gov. George W. Bush - who allowed the measure to become law without signing it because of concerns about its impact on health-**care** costs. On the presidential campaign trail, Bush now touts the measure as evidence of his record as a "reformer with results" and says he would favor similar legislation on the national level.

But critics of the Texas law warn that its true impacts are yet to be felt.

"Those who draw a conclusion that the flood of lawsuits didn't happen are premature," said Jerry Patterson, executive director of the Texas Association of Health Plans.

The Texas law is being challenged in a federal appeals court, which will decide whether the law is superseded by federal law that prohibits such lawsuits. If the Texas law is upheld, Patterson predicted that there could be many more lawsuits. He said attorneys have been holding seminars around the state to teach lawyers how to sue HMOs successfully.

Costs will rise, agencies warn

In Washington, some state agencies issued warnings about the potential costs of the state's Patient Bill of Rights as it sailed to Locke's desk with broad bipartisan support. Early estimates are that the measure could add $34 million to health-insurance costs for state employees - a daunting price tag in the post-Initiative-695 era of shrinking tax revenues.

Some analysts say that medical costs could balloon, either because of multimillion-dollar lawsuit awards against health plans, or if the plans feel pressured to approve unnecessary medical treatments as a precaution against lawsuits.

According to industry studies, every 1 percent increase in health-**care** costs means 8,400 Washington residents lose coverage, either because they or their employers can't afford it, said Karen Merrikin. The director of health policy development for Group Health Cooperative of Puget Sound, she testified before state lawmakers in January. Merrikin said the industry predicts that Washington's Patient Bill of Rights could boost insurance costs by 2 to 8 percent.

But in Olympia and across the nation, worries about costs are being trumped by high-profile stories of how **managed-care** plans have interfered with the doctor-patient relationship.

When health-care costs skyrocketed in the 1980s, many employers turned to **managed care** to control costs. HMOs and other forms of **managed care** encouraged prudence and careful oversight by refusing to pay doctors for performing what the plans considered unnecessary tests or procedures.

But those strategies produced horror stories about patients who claimed they were denied coverage for lifesaving treatments. **Managed-care** reform has become a huge national issue, with Congress now negotiating over a national patient bill of rights and presidential front-runners Bush and Vice President Al Gore both pledging their support.

The role of independent review

Under Texas' new patient bill of rights law, the lawsuits filed so far allege that penny pinching by **managed-care** outfits has interfered with sound medical judgments, with disastrous results.

In one case, a 66-year-old woman with a cancerous tumor in her jaw claims she was unable to get a referral from her doctor - the doctor she also worked for - to begin chemotherapy with an oncologist. The doctor was allegedly reluctant to refer patients to specialists because of an HMO plan, later ruled illegal, that put more money in the pockets of physicians who were stingy with referrals.

She eventually got the chemotherapy. But the woman, who is terminally ill, claims the delay blocked her chance at recovery.

In another case, a 68-year-old man with a history of depression killed himself just one day after being discharged from a hospital where he had been admitted after an earlier suicide attempt. His family sued, claiming the hospital prematurely discharged him because of HMO regulations discouraging long hospital stays.

In both of those cases, the lawsuits come too late to save the patients involved. That's why insurers, lawyers and doctors agree the most important part of the Texas law is that it gives people the right to an independent review of HMO decisions.

"That's been the ticket, that's been the most important part," said Dr. Paul Handel, a Houston urologist.

The reviews, similar to those which would be allowed by Washington's Patient Bill of Rights, are conducted by three independent review organizations certified by the Texas Department of Insurance. Doctors review cases where insurers

deny coverage as medically unnecessary.

The results of the reviews have been almost evenly split.

As of January, 791 complaints had been fielded by the independent review organizations. In 365 cases, the insurers' refusal to authorize a treatment was upheld. In 374 cases, their decisions were overturned. In 52 cases, their decisions were partially overturned.

For Jackie Burros, a Fort Worth woman fighting breast cancer, an independent review allowed her to win treatment for lymphedema - a painful swelling of the limbs caused by the removal of her lymph nodes during treatment for the cancer.

Burros is a serene woman who maintains a cheerful outlook despite a five-year battle with breast cancer and two mastectomies. A sign in her bathroom says, "Good morning, this is God. I will be handling all your problems today."

But that optimism didn't come so easily last year. After an exhausting regimen of chemotherapy, Burros said her HMO refused to authorize the lymphedema treatment her doctor insisted was necessary.

Burros' condition is treatable with specialized massage and tight-fitting fabric sleeves that keep the lymph fluid from building up in her arms. Her insurer, Harris Methodist, had approved the treatment in 1995 following Burros' initial diagnosis. But Harris denied the treatment last year when Burros and her doctor sought it again.

In February, the independent review organization ruled that Burros' lymphedema treatment was medically necessary, overturning Harris' denial.

"Thank God," said Burros.

Threat of lawsuit is powerful

Sometimes just the threat of an independent review or a lawsuit is enough to persuade reluctant HMOs to authorize medical care.

Cynthia Vance, a Fort Worth mother of three, fought successfully to get her HMO to pay for nursing care for her 19-month-old son, Jordan, who was born nearly four months premature.

Jordan suffers from underdeveloped lungs and a windpipe so narrow he would suffocate if not for the tube in his neck. He is

fed through another tube attached to his belly.

All of these conditions are normal for premature babies, says Dr. John Pfaff, a pediatric pulmonologist who treated the boy. With proper care, Jordan will probably grow up to be a healthy, normal child, Pfaff said.

In fact, he could have been sent home from the hospital several weeks earlier if his insurer had not resisted paying for in-home nursing care. Without that care, Pfaff said, he refused to let Jordan be discharged, even though the insurer was threatening to stop paying for his care.

"There's no doubt in my mind the child's life would have been imperiled," Pfaff said.

After months of wrangling and a call to Young, the Fort Worth attorney, Vance got the HMO to pay. Vance is convinced the law gave her the leverage she needed.

Handel, the Houston urologist, said the law hasn't erased all his concerns about **managed care** but it has provided more tools to people like Vance.

"There have been fewer problems. That is a sense across the state," Handel said. "To my thinking there really has not been a downside."

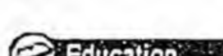
Jim Brunner: 360-236-8266.

EARN GOOD MONEY.

[seattletimes.com home]
[Classified Ads | Yellow Pages | Contact Us | Search Archives]

Copyright © 2000 The Seattle Times Company

Back to Top



Index

Office of the Governor

Date: March 15, 2000
FOR IMMEDIATE RELEASE
Contact: Governor's Communications Office, 360-902-4136

Locke signs 'Patient's Bill of Rights' legislation

TACOMA - Gov. Gary Locke today took a giant step in helping people get the care they need from managed health care providers.

Locke signed into law what has been called a "patient's bill of rights" that strikes a balance between providing quality health care and containing rising health-care costs. The legislation will make sure consumers can get information to make informed decisions when they purchase health care and hold accountable their health care plans.

"It's just unacceptable that medical treatment can be delayed because HMOs and insurance companies question a doctor's diagnosis," Locke said. "People need to be able to make decisions about their health care with their doctors, not insurance companies, accountants or auditors."

Sen. Lorraine Wojahn, prime sponsor of the bill, echoed the governor's comments.

"I am calling the patient's bill of rights a 'people bill,'" she said. "A life can sometimes hang in the balance while an insurance company decides whether or not to pay. Without the protection of this bill, people could be forced to suffer needlessly or, yes, even die."

The legislation provides several basic rights:

- A fast and impartial grievance process to resolve health care disputes.
- A timely external and independent medical review of health care disputes.
- The right to sue managed care plans if patients believe their managed care system has harmed them through negligence.
- The right to get access to information about health care plans.
- Protection from unnecessary invasions of health care privacy.
- A health plan medical doctor who is a licensed doctor.

THE FOLLOWING PAGES MAY
NOT FILM LEGIBLY BECAUSE OF
THE POOR QUALITY OF THE ORIGINAL

Children

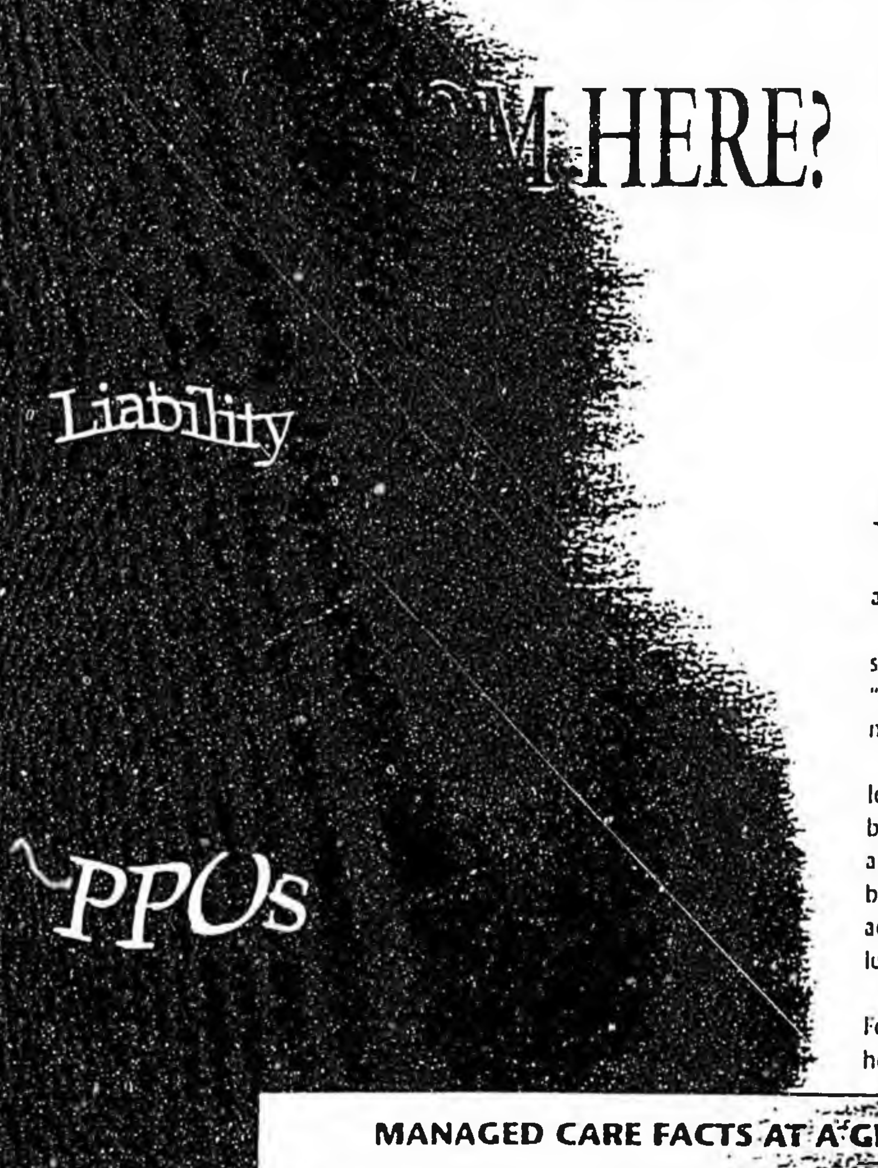
edicare

Specialists

Medicaid

Hospitals

Drugs



In 10 years, managed care has changed the landscape of American health care, saving money, simplifying paperwork and engendering lots of new legislation — but all the problems haven't been solved.

By Richard Cauchi

When Helen Hunt's character in the movie "As Good as it Gets" blasted her managed care plan for not giving her asthmatic son the help he needed, audiences cheered.

Is dissatisfaction with managed care organizations as widespread as headlines lead us to believe? Or are we in danger of "over-managing" managed care, defeating its purpose with micro-oversight of health care decisions?

Certainly the 1998 congressional debate about patient protection legislation caught the public's ear. Meanwhile, the real action has been in state legislatures. Between 1994 and 1998, 39 states approved "patient protection acts" or "comprehensive consumer bills of rights" affecting managed care. Eleven of those were adopted in 1998. The remaining 11 states have considered similar legislation.

Much legislative activity is driven by consumer complaints. For example, legislators heard about women being released from hospitals less than 24 hours after delivering babies because managed care plans wouldn't pay for longer stays. Under this so-called "drive-through delivery" practice, most women and babies did fine, but some had serious problems. In the first year after this issue made headlines, 27 states enacted laws requiring coverage for longer stays, typically 48 hours.

In Colorado, a personal story came from a mother who also happened to be a legislator and chair of a legislative health committee. During a 1998 managed care hearing, she told of her daughter, "Marcia," who was diagnosed with uterine cancer at age 30. Marcia's older sister also had the disease at a young age, resulting in a hysterectomy several years previously. With Marcia's diagnosis and family history, her doctor recommended a full hysterectomy. But her health maintenance organization (HMO) said "no, it would pay only for a partial procedure," and continue to monitor her condition.

MANAGED CARE FACTS AT A GLANCE

- HMO enrollment reached 83.7 million in 1997.
- Enrollment in preferred provider organizations (PPOs) reached [illegible] in 1997.
- Insurance companies own 60.4 percent of PPOs.
- Fifteen of the top 25 HMO plans are nonprofits.
- There were 757 licensed HMOs and 1,035 PPOs operating in the United States in 1997.
- Managed care enrolled 46.7 percent of the Medicaid population [illegible] 1997 (14.6 million people).
- HMOs enrolled 14.9 percent of the Medicare population in 1997 ([illegible] million people).
- After actually decreasing 1.3 percent in 1997 (from $434 to $429 for [illegible] coverage), health maintenance organizations' (HMOs) average monthly premiums are rising to an estimated $460 in 1999.

Richard Cauchi covers health insurance for NCSL at the Denver office. NCSL staff Molly Stauffer, Marla Rathouse and Jon Johnson Wilson contributed material used in this article.

SELECTED STATE LAWS ON MANAGED CARE / HMOs

STATE	Comprehensive consumer law (year)	Ban on financial incentives	Ban on gag clauses	Direct Access to ob/gyn	Continuity of Care	HMO Medical Director	Emergency Prudent layperson	Insurer Liability	Independent Review
Alabama	-			■		■			
Alaska	1998	■	■	**					
Arizona	-		■				*		■
Arkansas	1997		■	■**	■	■	■		
California	1994, '95	■	■	■	■	■	*		exp
Colorado	1997		■	■	■		■		■
Connecticut	1997		■	■**			■	hh	■
Delaware	Regulations	■	■	■	■	■	■		■
Florida	1997	■	■	■**	■	■	*		■
Georgia	1996	■	■	■**			■		
Hawaii	1998		■				■		■
Idaho	1997	■	■	■			■	hh	
Illinois	-			■					
Indiana	1998		■	■	■	■	■		
Iowa	Voluntary		■				■		
Kansas	1997	■	■		■		■		
Kentucky	1998		■	**		■	■		
Louisiana	1997	■	■	■			■	hh	
Maine	1996		■	■**			■	hh	
Maryland	1995	■	■	■	■	■	■	hh	■
Massachusetts	-		■						
Michigan	-		■				■		■
Minnesota	1997	■	■	■	■		■		
Mississippi	1995			■					
Missouri	1997	■	■	■	■	■	■	hh	■
Montana	1997	■	■	■**		■			
Nebraska	1998	■	■	■			■		
Nevada	1997	■	■	■		■	■		
New Hampshire	1997		■	■				hh	
New Jersey	1997	■	■	■	■	■			■
New Mexico	1998	■	■	■			*		■
New York	1996		■	■	■		■	hh	■
North Carolina	Regulations		■	■			■		■
North Dakota	-		■					hh	
Ohio	1997	■	■			■	■		exp
Oklahoma	1997		■			■			
Oregon	1997		■	■			■	hh	
Pennsylvania	1998	■	■	■	■		■		■
Rhode Island	1996	■	■	■		■		hh	■
South Carolina	1998		■	■	■		■	hh	
South Dakota	-								
Tennessee	1998		■	■	■			hh	■
Texas	1997	■	■	■	■	■	■	■hh	■
Utah	-		■	■					
Vermont	1996	■	■	■	■	■	■	hh	■
Virginia	1995, '98		■	■	■		■	hh	■
Washington	1996		■	■			■		
West Virginia	-	■	■	■			■		
Wisconsin	1998		■		■	■	■		
Wyoming	-		■						
Dist. of Columbia	1998		■	■	■				■
Puerto Rico	-								
TOTAL	39	22	46	37	20	18	31	1	22

** Alaska and Kentucky have direct access only to chiropractors; Maine covers ob/gyn and chiropractors; Arkansas also covers optometrists; Colorado, Connecticut, and Montana also cover advance practice nurses or midwives and Florida and Georgia also cover dermatologists.

Source: Health Policy Tracking Service, National Conference of State Legislatures.

* State has adopted a variation of the prudent layperson standard
hh = ban on health plan "hold harmless" clauses, which shift all liability to doctor or health facility
exp = applies to experimental treatments
Note: In some cases, state provisions are contained in regulations or administrative code.

"I believe the HMO made its decision based on financial considerations and not on what was best for Marcia," asserts her influential mother. She believes legislators play an important oversight role to protect consumers.

Another issue making headlines concerns access to emergency services under managed care plans. When 2-year-old Michael Silver cracked his head open on Thanksgiving eve several years ago, his parents rushed him to the nearest emergency room, five minutes away. The child received three layers of stitches from a plastic surgeon, but the family's HMO refused to pay the $560 bill because Michael's case didn't constitute an "emergency" under the plan. Nor had his parents contacted the HMO for prior permission to take him to a facility outside the network.

"My son was gushing blood. I was scared to death, and my hands were holding his wound shut," reports Michael's mother. "It certainly was an emergency in my mind, and it never occurred to me to take him the 40-minute drive to our HMO's closest emergency center or to call them up. Getting my baby immediate help was all that was on my mind."

In response to similar cases, more than 30 states have implemented "prudent layperson" standards to make getting emergency care easier. Such laws require plans to cover emergency care if a "prudent layperson" believes that immediate treatment is needed.

Personal stories such as Marcia's, Michael's and others made managed care a top constituent issue for many state legislators in the 1990s. With lives, livelihoods and votes at stake, states acted decisively. Among the 50 states, nearly 900 laws passed that affect managed care, according to NCSL's Health Policy Tracking Service (HPTS).

PRO-CONSUMER LEGISLATION

State laws addressing these issues have not followed any single model act, although insurance regulators, physicians and consumer advocates have circulated several such examples. In fact not all were high visibility packages. Many of the 900 state laws addressed particular issues reported by consumers negotiating the managed care system, such as gaining access to a specialist, being fully informed of medical options, getting coverage for emergency room services, obtaining 48-hour hospital coverage following birth for maternity cases, receiving adequate hospital coverage for mastectomies, appealing a denial of coverage for a specific service or procedure, or even just knowing what is covered.

Along the way, legislatures also have addressed structural and financial issues not as visible to the individual enrollee. These include: requiring consumer "report cards," requiring all HMO medical directors to be licensed MDs, allowing more providers to join health plans, requiring advance notice when terminating doctors and other providers and requiring prompt payment for doctors or specialists.

Many of these recent laws expand state authority or mandate additional action or services. However, at the same time, the legislative sponsors generally made it clear that they did not intend to restrict enrollment or hurt the growth of managed care plans. In fact, some would say the pro-consumer regulations may well make HMOs more acceptable and ultimately more popular.

With all these laws in effect, has managed care finally been "managed?" For 1999, many legislators would answer, "No way!" An HPTS survey of legislators active in health issues conducted in December indicates that managed care in general is still a priority in all 50 states and D.C.

Others worry, however, that overregulation of managed care plans may defeat their very purpose. While the horror stories make the headlines, the reality is that managed care has become a way of life for most Americans. At last count, more than 160 million people were enrolled in some form of managed care. These plans appear to serve the needs of many enrollees, especially those with few

SOME STANDARD FEATURES

After five years of state actions some clear trends have emerged for managed care. At least 20 states have enacted laws with these requirements:

◆ **Any willing provider:** In response to complaints that consumers want to use a local drug store, 22 states require that managed care organizations allow any pharmacy to be a provider to their enrollees; several states also include doctors or other providers.

◆ **Bans on gag clauses:** Forty-six states have laws prohibiting any agreement that limits doctors' ability to inform patients of treatment options, especially if some choices may cost the insurer more. A 1997 federal law now bans gag clauses for Medicaid and Medicare managed care.

◆ **Bans on financial incentives:** Twenty-two states prohibit a managed care plan from rewarding doctors for performing a less costly procedure or prescribing a less costly drug.

◆ **Direct access to women's health specialists:** Thirty-six states and the District of Columbia now allow women to see an obstetrician or gynecologist without first getting permission or a referral from a primary care provider.

◆ **Hospital stay after childbirth:** Forty-three states require reimbursement for (typically) at least a 48-hour maternity stay. A federal law requiring coverage for a 48-hour stay took effect in January 1998.

◆ **Independent review of denials:** Twenty-one states and the District of Columbia now require an independent panel to evaluate the validity of denied care. Once opposed as too costly by the managed care industry, this idea now is embraced as a "reasonable" alternative to court suits. In Texas, an HMO association actually urged a federal judge to retain that state's external appeals process. Aetna, the nation's largest managed care company, has announced it will voluntarily allow such appeals for enrollees in 30 states, as of June 30, 1999. In addition, all 50 states require some form of internal appeal for denials of care.

◆ **Prudent layperson standard for emergencies:** Thirty-one state laws specify automatic coverage for emergency medical conditions, of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy.

◆ **Financial standards and licensing:** All 50 states provide for structural regulation of managed care organizations, usually requiring a "certificate of authority" to operate, financial solvency standards, periodic reporting and filing of operational plans.

INNOVATIVE AND CONTROVERSIAL IDEAS

As the managed care debate evolves in the media and on the floor of state legislatures, new (some might say far-reaching) provisions have been enacted by selected states:

◆ **The right to sue your HMO:** Texas is the first state to enact an "insurer liability" provision that holds health maintenance organizations liable for health treatment decisions. Missouri used another approach by repealing an earlier law prohibiting the "corporate practice of medicine." Health plans decry right to sue provisions and say they will prompt premium increases of up to 10 percent; in addition federal law limits the reach of states' authority. However, 31 states reported that this is a legislative issue for 1999.

◆ **Report cards:** In an effort to assist consumers in choosing a plan, 11 states now require publication of an evaluation booklet, commonly called a "report card." In Vermont, for example, the public report card will measure how well plans are complying with about 60 selected state laws and regulations. "Ultimately it will be a great tool for consumers," noted William Little of Kaiser Permanente, Vermont's largest HMO.

◆ **Specialists as primary doctor:** For people with a single chronic health problem, the usual procedure of calling a primary care provider first can be frustrating and unproductive. In 1998, Indiana, Kentucky, New Mexico and Pennsylvania joined New Jersey, New York and Texas in allowing an enrollee to select a specialist (such as a neurologist, a mental health provider or a cancer specialist) to be their main provider.

◆ **Medical director requirements:** Some managed care organizations' chief officers have business degrees rather than medical credentials. In the past two years, 18 states have established specific qualifications and responsibilities for HMO medical directors; most require a current in-state medical license. Several states make such directors "responsible for treatment policies...of the carrier," which means they could be legally liable for actions of their staff.

◆ **Consumer assistance/ombudsman programs:** Over a dozen states established ombudsman programs for Medicaid managed care. Now California, Maine and Vermont have launched such publicly funded advocacy programs for private market enrollees, and other states are looking closely at these examples.

major health problems. And they do so with fewer complaints than most people believe.

Some legislators are looking for a middle ground. "Yes, I believe some regulation is necessary, but we don't want to drive HMOs out of business," says Representative Gregg Underheim, chair of the Wisconsin Assembly Health Committee. He adds, "Some HMOs behave very appropriately. Clearly there are some bad actors in the HMO industry and they are making the environment more difficult for those who have operated ethically and efficiently."

Representative Gregg Underheim Wisconsin

"It was really the private employer who caused the rapid growth of managed care over the last decade," says John Iglehart, founding editor of *Health Affairs*, a leading national journal. "It wasn't really until the private sector came along with the private employer's contribution and decided that rather than put it into indemnity insurance, which was uncontrolled at that point, they would move into managed care.

"So we should remember that the conflict and the commotion really isn't a consequence of governmental action — governments we all like to kick around; it really was a result of private decision making," he says.

MANAGED CARE HERE TO STAY

Agree or disagree, policymakers recognize that managed care is here to stay. The business community accepts the analysis of health leaders such as Stanford University's Dr. Alain Enthoven that managed care has the best chance of increasing access, improving quality and moderating the rate of increase in health care costs.

For private employers and governments alike, the biggest HMO success story is cost savings.

"The role of managed care is to attack unnecessary and inappropriate costs," says Stephen de Montmollin, vice president of WMed Health Plan of Florida, a managed care plan. "Double digit inflation caused millions to lose access to affordable health care insurance," he emphasizes. "In 1988, the average per employee cost for medical benefits in the United States shot up 18.6 percent; in 1989, another 16.7 percent, in 1990, up 17.1 percent, in '91 up 12.1 percent. With managed care, these figures have been reduced dramatically, with increases below 2 percent for 1998. In 1997, premiums actually decreased by 1.3 percent."

Citing several national and local polls, de Montmollin also says that most Americans, including those enrolled in managed care plans, are satisfied with their health care coverage. He also warns that burdensome regulations will result in higher costs, and that the alternative to a managed care system often is "uncoordinated care. Don't put the entire managed care system at risk in the absence of conclusive evidence that there is some systemic problem."

A SYSTEMIC PROBLEM?

Others believe there is a systemic problem. "The U.S. health care system is in chaos," asserts Ted Lewers, a vice chair of the American Medical Association's executive committee. "A lot of the satisfaction statistics that you've seen are from people who probably have not used the health care system—who have not had any chance to know whether it works or doesn't work.

"For example, if you look at mental health care, only 7 percent of Americans use those benefits. So if you look at your satisfaction questionnaire, you'd say you're satisfied with your mental health coverage, even if you haven't used it," he points out.

Many people aren't aware of the innovative things HMOs do, de Montmollin counters. Commenting on the Helen Hunt character and her asthmatic son, he says, "The irony is that many HMOs have been pioneers in putting together comprehensive asthma programs that help children control their symptoms and reduce

continued on page 19

WHAT ELSE TO LOOK FOR IN 1999

◆ **Higher premiums:** After several years of almost level rates charged to employers and consumers, premiums are headed up. The latest survey, released in January, confirmed HMO premiums are rising 8 percent to 10 percent this year, the largest jump since 1993 (the year of President Clinton's national health reform proposal). At the same time, traditional indemnity health insurance rates also are rising 8 percent, but HMO premiums remain about 20 percent cheaper.

However, copayments and deductibles will become higher and more widespread, as many employers seek ways to continue health benefits for employees without footing the entire bill. Some state regulators may again examine the possibility of capping certain insurance rates.

In the private market, the Midwest Business Group, representing 110 large employers in 11 midwestern states, is "strongly encouraging members to hold the line on premium renewals and to consider tactics such as freezing enrollment in plans where there are large rate increases, raising copayments and deductibles for employees, and warning employees that more drastic changes might be contemplated," according to Larry Boress, the group's vice president.

◆ **Prescription costs:** Most analysts, including the federal Health Care Financing Administration (HCFA), say the main cause of 1999 rate increases is pharmaceutical prices, which are up about 17 percent since last year. Perhaps that's why 24 legislatures say they will look more closely at drug costs, either through regulating formularies and generic substitutes or acknowledging special drug copayments.

◆ **Slow-down of government program enrollment:** After almost a decade of enthusiasm for enrolling Medicaid consumers in managed care, the focus is shifting. There is more emphasis on enforcing the rights of consumers, as well as legislative studies and audits to determine if cost savings are real, and if they can continue. Meanwhile, a push to enroll Medicare recipients in managed care collapsed in a high-visibility dispute between HCFA and managed care organizations about reimbursement rates. HMOs in 29 states announced they were pulling out of the Medicare market, affecting over 450,000 seniors. This dispute may fuel state legislative oversight hearings and investigations, although the resolution remains under federal jurisdiction.

◆ **Direct contracting:** Many large employers and some smaller ones are watching very closely an experiment in Minneapolis-St. Paul. A business consortium has pooled resources to contract directly with doctors and hospitals to provide health care, effectively bypassing HMOs. Policymakers in some other states may conduct their own studies to determine how direct contracting might work in their regions.

◆ **Voluntary improvements:** The American Association of Health Plans is putting its faith in improving quality and in convincing consumers that new regulatory burdens will make things worse, says Karen Ignani, trade association president and corporate executive officer. She expects a "continued evolution" that puts consumers in the driver's seat by giving them more choice of providers and benefits.

However, legislators remain skeptical. As Massachusetts Senator Mark Montigny, chair of the Senate Ways and Means Committee and chief sponsor of a 1999 consumer rights bill, notes: "Health care decisions are now driven by third party money managers, obsessed with the bottom line. A comprehensive managed care reform bill will restore the provider-patient relationship and ensure quality health care delivery at reasonable cost. Angry consumers will demand reform in 1999 and we must act with an aggressive bill that puts patients first."

Senator Mark Montigny Massachusetts

◆ **Health vouchers:** Some private sector employers are proposing a simplified voucher system, providing each employee with a standardized monthly payment. This could get employers out of the health decision business in which they have to preselect a limited list of health plans. However, some policymakers question whether the average employee will be able to pick up the remaining costs, especially of family coverage. Expect to see some state interest in either encouraging or further regulating such arrangements.

◆ **Congressional action**. Both parties in Congress and the Clinton administration have said "patient protection" is a top priority for 1999. In the wake of last year's debate over sharply differing bills, key questions are not yet resolved: Will a new federal law replace or preempt existing state laws, especially when the state law is stronger? Will it fully cover other insurance plans that now are outside state regulatory authority?

"The future of state regulation of insurance hangs in the balance of the ongoing debate on regulating managed care," notes Joy Johnson Wilson, director of NCSL's Health Committee.

(Continued from page 18)

the need for emergency hospitalizations."

In fact, says de Montmollin, the most noteworthy thing about the movie scene is that a single waitress in a diner has health insurance for her son at all. "Wow, that's fabulous—fewer than half the women in her situation have any access to coverage," he says.

Rising costs make it harder for businesses and governments alike to provide coverage for the nearly 44 million Americans who remain uninsured. Managed care has been touted as a way to save money that can be used to cover additional people. However, the numbers of uninsured have increased in the past 10 years.

Compared to other insurance, "HMOs generally offer more benefits, including coverage for prescription drugs, and fewer deductibles and copayments," notes William Falk of Towers Perrin, a research firm in Chicago. He expects most employers to stick with HMOs. They are "still an attractive alternative."

But striking a balance between consumer protections and micromanagement remains a challenge.

CONSUMERS NEED HELP

Establishing publicly funded consumer assistance or "ombudsman" programs may be one way to address consumer needs without overregulating managed care plans.

"The public is very confused," says Ron Pollack, executive director of Families USA, a consumer advocacy group. He says the managed care backlash comes from a variety of factors. "I think people clearly do not understand

Come to Jacksonville for the Assembly on State Issues (ASI) Spring Meeting

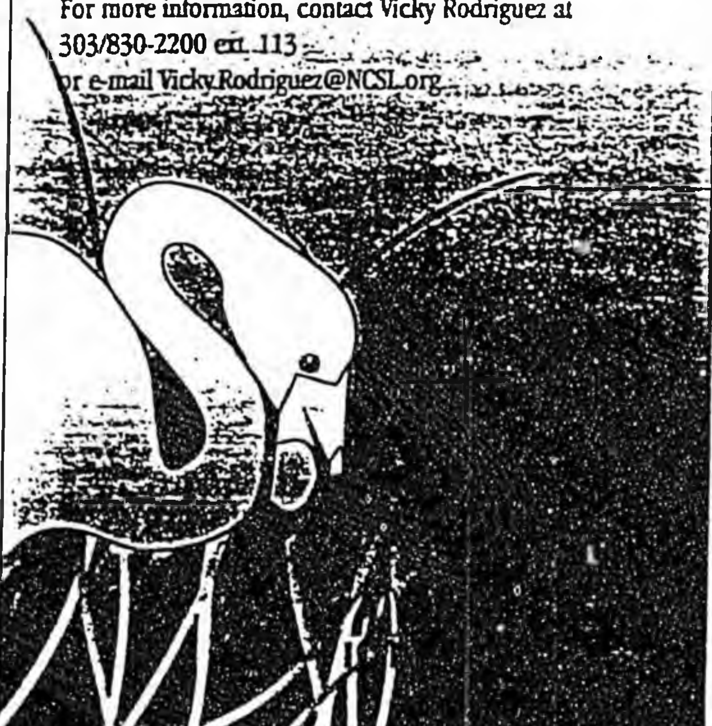
April 9-11, 1999
Omni Jacksonville and
Jacksonville Hilton & Towers

The ASI Spring Meeting is your Capitol-to-Capitol Connection. Through this forum, both legislators and staff come together to discuss issues and ideas. With eight standing committees and a task force, ASI members address many topics:

- children, families and health
- communications and information policy
- criminal justice
- economic and cultural development
- education
- fiscal, oversight and intergovernmental affairs
- legislative effectiveness
- science, energy and environmental resources
- redistricting

You do not need to be a committee member to attend this meeting. Everyone is welcome.

For more information, contact Vicky Rodriguez at 303/830-2200 ext. 113 or e-mail VickyRodriguez@NCSL.org



FOR MORE MANAGED CARE INFORMATION, ORDER THESE NCSL REPORTS:

— *Health Care Legislation*, 1997 (#6669) and 1998 (#6674) editions.
— *1999 State Health Care Priorities* by the Health Policy Tracking Service (#3029).
— Issue Brief: *Comprehensive Consumer Rights Bills*, by the Health Policy Tracking Service (#0233).
— *Major Health Care Policies: 50 State Profiles*, 1998 (#3027).
— Also check out NCSL's Health Care Web index: www.ncsl.org/programs/health/hc

For NCSL publications call the Marketing Department at (303) 830-2054. The Health Policy Tracking Service material is also available from Jeff Strandberg in NCSL's Washington, D.C., office: (202) 624-8695.

today what their choices are, what their rights are and how they can claim those rights. To the extent that we're really going to address the core of people's problems or concerns, we need to provide some specific assistance to consumers."

Pollack says consumer assistance programs would give people information about plans, help them understand their choices and rights, answer questions through free phone access, and help those who want to file an appeal. He also says that such programs can help the managed care plans, employers and regulators. "They can provide a basis for getting quick information about what the problems are that arise as our health care system changes."

"A 'patients bill of rights' should not dictate clinical decisions or redesign health benefits packages," Pollack says. "But such state laws are very important because they help to ensure that patients get the care they need, when they need it. And they give patients and physicians effective tools to fight HMOs' wrongful denials and delays of care," he explains.

THE FUTURE

Evidence points to continued lively and high visibility debate about managed care, including new state laws, renewed congressional debate and more indepth studies of the effect of the recent state laws.

"What will eventually shake out as the health care system in the next century likely will be a muddle of market, policy, regulatory and professionally driven solutions," says Edward O'Neil, director of the Center for the Health Professions at the University of California.

"Such pluralistic approaches are typically the American way of doing things. The best solutions occur when we are clear about our aims and use the various vehicles of market, policy and professions to implement what we desire. But in this case, we do not have the capacity to generate a community or public definition of aim. Until we find a genuine voice for the varied interests in health care, we are likely to continue to suffer the cacophony of competing interests clashing over the $1.1 trillion that is health care in America, and to blame managed care for it all."

H B 211
3/24/00
JLD

Blue Cross
Blue Shield of Alaska
A PREMERA HEALTH PLAN
P.O. Box 327
Seattle, Washington 98111-0327

March 21, 2000

Repres ..ive Pete Kott
Chairr. .n House Judiciary Committee
State Ca| .ol, Room 118
Juneau, AK 99801-1182

As you know, Blue Cross Blue Shield of Alaska (BCBS of AK) has been working with Representative Norman Rokeberg on HB 211, the Patients' Bill of Rights with the goal of providing Alaskans with the best health care coverage possible.

As we discussed in meetings with Representative Rokeberg, we are supportive of a number of concepts in HB 211. However, we do have concerns with aspects of the bill that have the potential to substantially drive up costs in Alaska to our approximately 100,000 subscribers, while at the same time, not creating a corresponding improvement in the health care delivery system.

BCBS of AK does support concepts in the bill dealing with patient and healthcare provider protection; required contract provision; confidentiality and external health care appeals. We do believe, however, that we need to continue working together on the language in these sections so that the final bill will benefit both the health care delivery system and our subscribers.

At a time when the national uninsured population is reaching almost 50 million and when national statistics reflect that more and more employers are making the decision NOT to provide health care to their employees, BCBS of AK cannot support sections in the bill relating to liability and concepts relating to any willing provider. We believe that this is not the time to address these issues in lights of these trends.

BCBS of AK has historically provided high quality coverage to Alaskans. We have also focused on holding down health care costs to the highest degree possible. Recent studies by the Congressional Budget Office and the firm of Milliman & Robertson have shown that similar Patients' Bill of Rights Legislation at the Federal and Washington State level will increase insurance premiums by as much s 4%. To put that percentage into perspective, for BCBS of AK members, the passage of this bill has the potential to increase Alaska premiums by $5.6 million, not including the 30,000 individuals covered under the Federal program. This would be on top of the 12% increase that Alaska State's health benefit consulting firm of Watson Wyatt has projected.

Thank you for your consideration of our thoughts. We look forward to working with you in establishing a Patients' Bill of Rights that will enhance healthcare for all Alaskans, while not increasing cost to a point where it becomes unaffordable for many residents.

Sincerely,

Jack C McRae

Jack C. McRae

3/31/00
JUD

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS

LABOR &COMMERCE COMMITTEE, CHAIRMAN
JUDICIARY COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON UTILITY RESTRUCTURING, MEMBER
SPECIAL COMMITTEE ON ECONOMIC DEVELOPMENT & TOURISM, MEMBER

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

INTERIM
716 WEST 4TH AVENUE, SUITE 640
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX (907) 269-0119

SESSION
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4986
FAX: (907) 465-2040

Representative Norman Rokeberg

Sponsor Statement for CSHB 211 (L&C)

Alaska Patients Bill of Rights

An Act relating to liability for providing managed care services, to regulation of managed care insurance plans, and to patient rights and prohibited practices under health insurance; amending Rule 602(b), Alaska Rules of Appellate Procedure; and providing for an effective date.

Updated: March 18, 2000

Patients need assurance that the quality of their health care will not be compromised as managed care expands. CSHB211 (L&C) requires managed care entities to provide a reasonable standard of health care, and holds them civilly liable if they do not. It also establishes requirements for contracts between managed care entities and their health care providers, patients and their group managed care plans, and health care insurers and their insureds, providing patients with the following:

- access to emergency room services
- availability of medical services or adequate referral options
- full disclosure of treatment options
- choice of health care providers, including specialists
- clear descriptions of covered items and services, benefits, procedures, compensation methods, availability (and exclusions) of prescription medications and the availability of translation or interpreter services
- a point-of-service plan option
- follow-through of preapproved payment
- quick utilization review decisions
- opportunity for appeals of utilization review decisions
- added protection from denial, reduction, or termination of payment for health care services

In addition, this legislation gives health care providers the freedom to share all testing and treatment options with their patients, and lets them advocate for their patients without the risk of being penalized or terminated by the managed care entity they contract with. It also prohibits contracts between managed care entities and health care providers from including "hold harmless" clauses for the managed care entity or financial incentives for providers to withhold medically necessary services.

While it streamlines the health care system, managed care may also increase the vulnerability of patients and doctors, resulting in a lower quality of care. HB211 is necessary to ensure continued quality health care in the face of a growing managed care industry.
I urge you to support this legislation.

AETNA State Employee Plan.

6/16/00
HB 211
JUP

COVERED MEDICAL EXPENSES

The medical plan provides extensive and valuable benefits for you and your eligible dependents. Benefits are available for medically necessary services and supplies necessary to diagnose, care for, or treat a physical or medical condition.

To be medically necessary, the service or supply must be:

- care or treatment which is expected to improve or maintain your health or to relieve pain and suffering without aggravating the condition or causing additional health problems;
- a diagnostic procedure which is expected to provide information to determine the course of treatment; and
- no more costly than another service or supply which could fulfill these requirements.

In determining if a service or supply is medically necessary, the claims administrator will consider:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and

- any other relevant information brought to the claims administrator's attention.

In no event will the following services or supplies be considered medically necessary:

- those that do not require the technical skills of a medical or dental professional who is acting within the scope of their license;

- those furnished mainly for the comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care provider or health care facility;

- those furnished only because the person is in the hospital on a day when the person could safely and adequately be diagnosed or treated while not in the hospital; or

- those furnished only because of the setting if the service or supply can be furnished in a doctor's or dentist's office or other less costly setting.

Physician's Services

The medical plan pays for covered medical treatment and surgery performed by a qualified physician. Providers who are covered by the plan are people licensed to practice:

- medicine and surgery (M.D.)
- osteopathy and surgery (D.O.)
- dentistry (D.D.S. or D.M.D.)

Also covered are:

- psychologists
- occupational therapists
- physical therapists
- licensed clinical social workers
- licensed marital and family counselors

EVIDENCE OF MEDICAL NECESSITY

The claims administrator may require that any person who receives services under this plan submit a certificate of medical necessity within a reasonable time from people or organizations considered appropriate. If evidence of medical necessity is requested, members cannot continue to receive benefits under this plan unless they provide a requested certificate, subject to a medical review board, that substantiates the medical necessity for continued care. The claims administrator will not request such a certificate more frequently than every 10 days.

FACILITY OF PAYMENT

Whenever payments which should have been made under this plan are made under other programs, this plan has the right, at its discretion, to pay over to any organizations making other payments, any amounts it determines are warranted. These amounts are considered benefits paid under this plan, and, to the extent of such payments, this plan is fully discharged from liability under this contract.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

You may select any hospital who meets the criteria on page 29. You may select any physician or surgeon who meets the definition of provider on page 27.

The payments made under this plan for services that a physician or surgeon renders are not construed as regulating in any way the fees that the physician or surgeon charges.

4/10/00
JUD
(Courtesy by Kohn.)

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

April 6, 2000

RECEIVED
APR 08 2000

Honorable Pete Kott
Chair, House Judiciary Committee
House of Representatives
State Capitol, Room 118
Juneau, Alaska 99811-1182

RE: CS HB 211—Alaska's Patients' Bill of Rights

Dear Representative Kott

CS HB 211 (version "N" as amended) contains some significant protections for Alaska's patients. However, the job is not yet completed. Two major issues remain—managed care entity accountability ("liability issue") and the issue pertaining to the definition of "medical necessity" with its impact on the external appeal mechanism and with liability.

Given the short time remaining in this session and the complexity of the above two issues; ASMA feels that those two issues cannot receive the amount of attention warranted for the Legislature to make a reasoned policy decision. ASMA also is very aware that Congressional action is expected on the "National" Patient's Bill of Rights (with such action possibly having an impact on what may or may not be adopted in Alaska). Therefore, it is ASMA's intent to come back to the Legislature early in the next session with separate legislation pertaining to those issues. Although, ASMA feels that the ERISA pre-emption of the various states regulating "quality of care" issues has been significantly narrowed through recent court decisions, it is expected that the "National" Patient's Bill of Rights will directly address that issue.

So, therefore, ASMA supports CS HB 211 version "N" as amended, as on balance it provides important patient protections, but the issues of "liability" and "medical necessity" still need to be addressed by the Legislature in the next session.

Thank-you for all the work you, your committee, and the special sub-committee has done on this important legislation.

Sincerely,

Peter Lawrason

BY: Peter Lawrason, MD, President
FOR: The Alaska State Medical Association

cc: Judiciary Committee Members
Rep. Joe Green
Rep. Jeannette James
Rep. Lisa Murkowski
Rep. Norm Rokeberg
Rep. Eric Croft
Rep. Beth Kerttula

kms

Alaska Physicians & Surgeons, Inc.
4120 Laurel Street, Suite 206
Anchorage, Alaska 99508
Phone: 561-7705 Fax: 561-7704
E-mail: akphys@alaska.net

RECEIVED
APR 08 2000

April 6, 2000

The Honorable Pete Kott
Alaska State House of Representatives
Room 118, State Capitol Building
Juneau, Alaska 99811

Dear Representative Kott:

Alaska Physicians & Surgeons supports amended version N of House Bill 211.
However, we have concerns about supporting a bill that does not have a definition of "medical necessity" nor c[illegible] amended version N of House Bill 211 managed care entities.

By supporting this version of HB211, we are not waiving our commitment to enact into law these two provisions. Given that there are only a few weeks of session left, we will pursue enacting these sections in separate legislation next year.

We appreciate your attention to HB211 and the work your committee has done, especially by Reps. Joe Green and Lisa Merkowski. We also look forward to working with you in the future to resolve the important issues left out of HB211.

Sincerely,

George S. Rhyneer, MD
Chairman and President
Alaska Physicians & Surgeons